University of Alberta

A Focused Ethnography of Preceptorship in Rural Hospitals

by

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Abstract

Rural hospital nursing practice is rooted in the experience of living within the rural community. The purpose of this study was to explore and describe the perceptions and experiences of undergraduate nursing students and nurse preceptors in a senior practicum in rural hospitals. Using a qualitative focused ethnography method, the researcher interviewed 12 fourth year nursing students and six nurse preceptors, and conducted a focus group to explore the experience, and social norms, values and practices of nursing students during their rural hospital preceptorship. The findings suggest that in the rural hospital setting, nurse preceptors assist students in becoming members of the team and foster the development of feeling like they belong to the nursing team and the rural community. So that students can feel like they belong, preceptors build bridges between the staff, patients, and students; theory and practice; and by bridging the gap between the student and graduate role. For students, developing a sense of belonging by becoming part of the team requires that they posses critical thinking skills, the ability to demonstrate professional skills, as well as the ability to engage in a variety of other behaviors. Students know they have become a member of the team and that they belong when they are known personally and professionally. Thus, understanding the interplay between the rural placement experience and the preceptoring experience of nursing students can assist nurse educators, preceptors, and students prepare for, and learn, in this particular setting. Additionally, identifying and describing factors that influence students' professional socialization enhances the effectiveness of the preceptorship model and increases the potential of recruiting and retaining competent health professionals in the rural hospital setting.

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CHAPTER ONE
INTRODUCTION

The nurse education literature is replete with the reported benefits of preceptorship and supports the notion that it is an effective teaching strategy (Clayton, Broome, & Ellis, 1989). Positive outcomes have been reported in areas of improved clinical competency (Letizia & Jennrich, 1998), increased self-confidence (Freiburger, 2002), and improved adaptive learning competencies (Laschinger & MacMaster, 1992; Stutsky & Laschinger, 1995). Therefore, the preceptored clinical practicum experience in the senior year of a baccalaureate nursing program is believed to facilitate the transition from student to graduate nurse role.

While role socialization is a topic that has captured the interest of nurse researchers over the years (Coudret, Fuchs, Roberts, Suhrheinrich & White, 1994; Reutter, Field, Campbell & Day, 1997), the effect of preceptorship on nursing student role socialization, that is the internalization of critical thinking and psychomotor skills, is yet to be established (Crawford, Dresen & Tschikota, 2000; Udlis, 2008). Further empirical studies are warranted to clarify the contribution of preceptorship in the professional socialization of undergraduate nursing students since nurse researchers are divided on when and how socialization occurs for nursing students. While some authors believe socialization occurs in the classroom as a result of the educational process (Crocker & Brodie, 1974), others believe role socialization can only occur in the practice setting (Olsson & Gullberg, 1991). Indeed, nursing students report the clinical experience is the most influential factor in the development of their nursing skills, knowledge, and professional socialization (Chun-Heung & French, 1997). Still other researchers state that

regardless of when socialization occurs, the preceptorship experience is valuable because it provides students with the opportunity to combine the ideals taught in the classroom with the realities of the practice setting (Coudret, Fuchs, Roberts, Suhrheinrick, & White, 1994). Indeed, preceptorships are thought to support the development of teaching/collaboration and planning/evaluation skills, as well as leadership and interpersonal relations/communication skills necessary for professional nurse roles (Udlis, 2008).

There is however, a potential for baccalaureate nursing students choosing a rural hospital preceptorship experience to have difficulty in becoming professionally socialized to the rural hospital nurse role. As nursing and health care become increasingly specialized, rural nursing has emerged as a unique, specialty area of generalist practice (Bigbee, 1993) requiring nurses to possess high level functioning in areas of "…social awareness, confidence, initiative, innovation, experience and problem-solving ability – skills that usually take years to acquire" (Huntley, 1994/95, p.14). Given the complex nature of the setting that requires nurses to have diverse skills in order to practice competently, some authors argue that it is not possible to prepare undergraduate nursing students for rural practice (Bell, Daly, & Chang, 1997; Huntley, 1995).

Many students in Alberta, Canada undertake a rural hospital preceptorship. Rural hospital preceptorships provide nursing students with an ideal opportunity to be immersed in the experience of rural nursing while under the supervision of experienced nurses. Since research examining the student experience is limited to the recruitment of students as a potential workforce (Armitage & McMaster, 2000; McAllister, McEwan, Williams, & Frost, 1998), or factors that influence students choosing to undertake a rural

clinical placement (Bushy & Leipert, 2005; Dobie, Carline, & Laskowski, 1997; Neill & Talyor, 2002), it is timely to begin to research this type of clinical teaching and learning experience.

Professional socialization of nursing students represents a type of outcome that is critical to the education process (Nesler, Hanner, Melburg, & McGowan, 2001). A lack of knowledge regarding the professional socialization of baccalaureate nursing students in the rural hospital setting represents a serious weakness for nurse educators relying on this type of clinical placement for their students given the current focus of accreditors and other evaluators of higher education on student outcomes (Peinovich, Nesler & Thomas, 1997). In light of the limited information regarding the professional socialization of nursing students in the rural hospital setting, factors that influence their socialization must be identified and described so that their meaning might be understood.

Purpose

The purpose of this study was to describe the experience of nursing students and preceptors during a rural hospital preceptorship. Specifically my goal was to identify and describe the norms, values, beliefs, and behaviors that influence baccalaureate senior nursing students' professional socialization during this preceptorship.

Significance of the study

The findings of this study contribute to what is known about preceptorship in Canada. They assist in identifying and describing some of the norms, values, beliefs, and behaviors that influence the professional socialization of baccalaureate nursing students in a rural hospital preceptorship. The study also describes the challenges of nursing practice in the rural hospital setting experienced by nursing students, preceptors, and

nursing educators. Because greater understanding of the interplay between the clinical placement and the professional socialization of students is achieved, nurse educators and preceptors can facilitate nursing students' preparation for and learning in this particular setting. Additionally, by identifying and describing factors that influence students' professional socialization, assessment of the outcomes of the preceptorship model of clinical instruction is more easily achieved, thereby enhancing the effectiveness of this model as a teaching strategy.

Research question

A focused ethnography seeks to answer research questions aimed at explicating select behaviors or beliefs in a specific topic area so that their meaning among a specific group of people might be understood (Morse & Richards, 2002; Muecke, 1994). Research questions are posed that can best be addressed through descriptive analysis and interpretation, and initially are broad questions addressing the area of inquiry (Germain, 2001).

The broad research question that guided this study was: "What are the experiences and perceptions of undergraduate nursing students and nurse preceptors during a rural hospital preceptorship?"

Subquestions that guided this study were: "From the student perspective, what are the norms, values, beliefs and behaviors that influence the professional socialization of baccalaureate nursing students during the senior, preceptored rural hospital clinical experience?" "From the nurse preceptor perspective, what are the norms, values, beliefs and behaviors that influence the professional socialization of baccalaureate nursing students during the senior, preceptored rural hospital clinical experience?"

Definitions

Definitions are statements that serve to illuminate the meaning of a word or the nature of a thing (The Canadian Oxford Dictionary, 1998): they help us understand a concept, idea, or notion. When I began this project, the definitions below were offered as beginning definitions to help ground my understanding. However, as the study progressed, these definitions evolved as I tried to understand the participants' world view. Consequently some definitions have been modified to reflect the participants' experiences.

Preceptorship: Although the term preceptorship is at times described as a formal one-to-one relationship of a predetermined length of time between a novice/preceptee (the nursing student) and expert nurse (preceptor) (Letizia & Jennrich, 1998), in this study, preceptorship came to be defined as a "joint effort" among all of the rural hospital staff. Preceptors relied on other staff members to assist in the students learning experience and so played an integral role in the preceptorship.

Novice/Preceptee: A fourth year baccalaureate nursing student undertaking a senior, preceptored clinical experience. Although it was assumed this individual had limited knowledge and nursing practice experience in the rural hospital setting, many of the student participants in this study had experience living in rural communities and/or working in rural hospitals. Therefore, most of the participants had knowledge of what it was like to live and/or work in a rural community.

Preceptor: Although most of the preceptors were experienced registered nurses (Letizia & Jennrich, 1998) in the rural hospital setting, one preceptor was a relatively recent graduate who was preceptoring for the first time.

***Professional socialization*:** This was described as the process by which knowledge, skills, behaviors, attitudes, intellectual and emotional comfort, and the internalization of values that support an individual's transition into the professional role are acquired (Brief, Sell, Aldag, & Melone, 1979; Cohen, 1981).

Rural: Although no universally agreed upon definition of the term "rural" exists in the literature, duPlessis, Beshiri, and Bollman's (2001) definition has gained wide acceptance. They define "rural" as "the population living in towns and municipalities outside the commuting zone of large urban centers, [with] populations of 10,000 people or more" (p.1). Because there were unique characteristics to the rural setting that included not only demographic and geographical data, but also included social, economical, and political factors that influenced one's perception of "being rural," for this study, rural was defined by the participants themselves.

Rural Hospital: A facility where patients could be admitted to the facility with the express purpose of receiving medical and nursing care. The facilities offered a limited number of services including ancillary services, had a smaller number of hospital beds,

and usually had a designation of "Community Health Centre or Complex" and municipal hospital.

CHAPTER TWO
LITERATURE REVIEW

The purpose of this literature review is to locate the proposed study in the context of the nursing literature that pertains to nursing students' professional role socialization during a rural hospital preceptorship. In a review of the literature, several themes emerged. First, there is an abundance of research examining various aspects of preceptorship within nursing education. Secondly, research with a rural preceptorship focus is limited in its depth and breadth of scope. And finally, although professional role socialization within the nursing student preceptorship experience has received attention, the impact of the clinical setting on this type of socialization has received limited attention.

Preceptorship

Since the 1960s, preceptorship has been a popular clinical teaching strategy in nursing education because of its perceived benefits in socializing students to the nursing profession, improving student clinical competency, enhancing students' ability to apply theory to practice, and increasing their familiarity with health determinants (Letizia & Jennrich, 1998). Consequently, the popularity of this teaching strategy is reflected in the abundant research that has been conducted in the last two decades examining the preceptorship experience from a variety of perspectives. One such perspective presented in the literature is that of the students' experience of being preceptored (Nehls, Rather, & Guyette, 1997). Although preceptorship is described by students as a positive experience overall, they may also feel uncertain because they may not know what to expect within and from the experience. Given this uncertainty, the preceptored experience has the potential to be stressful (Yonge, Myrick, & Haase, 2002), especially when conflicts occur

among the student, preceptor, and faculty member that often leaves the student to cope with the conflict in silence (Myrick, Phelan, Barlow, Sawa, Rogers, & Hurlock, 2006).

A reported outcome of preceptorship is the development of safe, clinically competent practitioners who can think critically and who are effective problem solvers (Scheetz, 1989). That is, after participating in a preceptorship nursing students typically report they feel more self-confident, which improves their level of competence (Freiburger, 2002). Improved self-confidence positively affects their adaptive learning competencies (Laschinger & MacMaster, 1992; Stutsky & Laschinger, 1995). A key factor affecting the degree of success of the preceptorship is the preceptors' ability to influence students' critical thinking skills while in the practice setting (Andersen, 1991; Myrick, 2002a; Myrick, 2002b). Preceptors also assist nursing students in becoming competent practitioners by providing students with opportunities to discuss nursing knowledge and by demonstrating nursing as a caring practice (Nehls, Rather, & Guyette, 1997).

Since preceptors are in a prime position to affect student learning and their socialization into the nursing profession, the selection and preparation of preceptors (Altmann, 2006; Myrick & Barrett, 1994; Oermann, 1996; Rittman, 1992; Yonge & Myrick, 2004) requires nursing educators' careful attention. Although baccalaureate prepared preceptors are thought to provide professional socialization for nursing students that is more consistent with the professional model of practice (Ouellet, 1993), many preceptors have a diploma of nursing as their highest level of education. Therefore, to facilitate student learning and socialization, preceptors themselves need support from

nursing educators in fulfilling their role and developing their teaching skills (Hsieh & Knowles, 1990; Yonge, Krahn, Trojan, Reid, & Haase, 2002).

While much research has been focused on the preceptored experience for nursing students in their senior clinical practicum (Hsieh & Knowles, 1990; Laschinger & MacMaster, 1992; Pond, McDonough, & Lambert, 1993) with the changing health care environment where patient acuity and shorter hospital stays have resulted in fast-paced, specialized, and technologically intensive nursing care, the feasibility of undertaking a preceptored clinical experience for junior nursing students is beginning to be examined (Beeman, 2001). As well, preceptorship in more specialized areas of care, such as intensive care and the operating room is also being explored (Ferguson, Whyte, & Anderson, 2000; Ihlenfeld, 2003).

In summary, although preceptorships are based on the premise that a one-on-one relationship facilitates effective learning (Clayton, Broome, & Ellis, 1989), their use has not been without critique. In one study, researchers concluded there was no convincing evidence supporting the use of preceptorship to promote the development of clinical competence in the practice area of public health nursing (Brehaut, Turik, & Wade, 1998). Furthermore, conflicting results in nursing performance between preceptored and non-preceptored nursing students in two separate studies (Myrick & Awrey, 1988; Yonge & Trojan, 1992) indicate that further research examining preceptorship is still needed.

Clinical setting for preceptorship

Myrick and Yonge (2005; 2001) state that the climate that includes each person within the agency as well as the physical structure of the unit, provides the context for the practice setting and is a teaching and learning determinant that is often times overlooked.

It would seem the match between available learning opportunities and students' learning priorities and course objectives (Ballard & Trowbridge, 2004) are the primary aspects of preceptorship that are considered by nursing educators when choosing a clinical setting for the preceptorship. In fact learning psychomotor skills, applying theoretical knowledge to situations where patients have complex nursing needs and varying prognoses, and developing knowledge of hospital policies are frequently discussed to the exclusion of the clinical context even though nursing students may be preceptored in highly specialized units of care available only in large urban centers. For example, preceptorships might be undertaken in intensive care and acute-care pediatrics (Ellerton, 2003; Ihlenfeld, 2003), or specialized units such as bone marrow transplant units, craniofacial clinics, and women's care and reproductive clinics (Cohen & Musgrave, 1998; Lunday, Winer, & Batchelor, 1999). Although nursing educators have demonstrated considerable creativity in developing preceptorship programs that are not only appealing to some nursing students but also have the potential to create a future workforce for specialized nursing care areas, giving students a choice of learning environments and activities (Allrich, 2001) may be more important to favorably impact their learning.

Rural preceptorship

Before discussing rural preceptorship, the characteristics of rural hospital nurses as well as the rural practice setting, need to be described since rural nurses and their practice are as diverse as the settings in which they work in (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004). Until recently, the demographic profile of Canadian rural nurses had never been analyzed. Reporting on demographic characteristics from a Canadian national survey, Stewart, et al. (2005) found the most notable differences

between rural and urban nurses are basic education (more rural nurses than urban nurses hold a nursing diploma as their highest level of education), the acquisition of additional qualifications (less than thirty percent of rural nurses have a degree or specific education for advanced practice), and the proportion of nurses who work part time and in multiple employment situations (at least half of the total number of rural nurses work part time).

A description of the rural hospital setting helps bring into focus what rural nursing practice might be like. Within the physical and socio-cultural context of sparsely populated communities, rural hospital nurses care for individuals across the lifespan who have a variety of health problems (Biegel, 1982; Bigbee, 1993; Bushy, 2005). As a result, rural hospital nurses require a wide range of clinical skills. They must have the knowledge and ability to work with multidisciplinary teams; provide care to special populations such as aboriginal, elderly, pediatric, newborns, and individuals requiring emergency and critical care; and be able to utilize community and health promotion knowledge (Bigbee, 1993; Bushy, 2005; Ross, 1999; Shellian, 2002) to function effectively in the rural hospital setting.

Although some nurses in urban centers also use a wide range of clinical skills in their practice, there are five main areas that make rural hospital nursing unique: close community ties and relations, multiplicity of functions resulting in assuming the role of "jack of all trades," high levels of independence and self-direction, greater cohesiveness and camaraderie among staff and within the community, and a high degree of visibility in the community (Bigbee, 1993). Furthermore, rural hospital nurses have their practice roots established in working alone and as a result, they have a high level of independence and autonomy (Andrews, Stewart, Pitblado, Morgan, Forbes, D'Arcy, 2005).

Although these factors serve to create a complex setting (Bigbee, 1993), other perhaps less obvious but no less crucial factors also have a significant impact on rural hospital nursing practice. The central theme of nursing practice in small rural and remote hospitals has been described by nurses as "We're it" (MacLeod, 1999). In MacLeod's study, nurses reported that the hospital was frequently the only facility open in town where people could receive help seven days a week, 24 hours a day. Even the local police used a telephone recording in the middle of the night to respond to calls for assistance.

Rural hospital nurses are often expected to be autonomous, "expert generalists" possessing a broad knowledge base. As self-directed thinkers, they provide care to clients with a variety of health conditions across the life span (Bushy & Leipert, 2005; Kulig, Stewart, Morgan, Andrews, MacLeod, Pitblado, 2006). Although rural hospital nurses may feel more comfortable in one clinical area (for example medical nursing), they are frequently required to practice in areas they may be less familiar with (for example obstetrics) and so may feel less competent. However, it is not uncommon for only two or three nurses to be working on a shift. Therefore, regardless of their level of comfort, a nurse might begin a shift in the emergency room assisting with victims of a motor vehicle accident, move to assist with the delivery of a premature baby, and complete the shift providing one-to-one nursing care for a child with a severe asthmatic episode. Furthermore, physicians may be available only on an on-call basis resulting in limited in-house medical support.

Regardless of the highly complex context in which personal isolation, lack of anonymity and resources, and coping with the realities of a stressful work environment, patients and their families expect that high quality nursing care will be provided

(Anderson & Yuhos, 1993; Bigbee, 1993; Davis & Droes, 1993; MacLeod, 1999; Shellian, 2002). They also expect rural hospital nurses to have current certifications in several specialties (Shellian, 2002). Although it would be ideal for them to hold current certifications in several specialty practice areas (Canadian Nurses Association, 2005), like the rural nurse practitioners surveyed in rural and outpost areas of Canada (Stewart & MacLeod, 2005), rural hospital nurses consistently report that there are significant barriers such as accessibility, time, and financial constraints (Penz, D'Arcy, Stewart, Kosteniuk, Morgan, & Smith, 2007) prohibiting the acquisition of additional qualifications.

Health care restructuring has also had a considerable impact on rural hospital nursing practice. The amalgamation of services through regionalization, hospital downsizing and closures, and shortened hospital stays has resulted in nurses being required to care for patients with increasingly complex problems. Since the health status of rural Canadians is generally lower than that of other Canadians, rural hospital nurses work with clientele that require more service and care (Hanvey, n.d.). There is little doubt then that the rural hospital setting is complex. It is not surprising rural nursing is regarded as a "…specialist area of advanced practice" (Neill & Taylor, 2002, p.239) requiring high levels of functioning in areas of "…social awareness, confidence, initiative, innovation, experience and problem-solving ability – skills that usually take years to acquire" (Huntley, 1994/95, p.14).

While preceptorship has not been limited to urban settings, the examination of nursing students' rural hospital preceptorship has received significantly less attention and is limited to two areas. The first area is the exploration of factors that influence nursing

students' choice in selecting a rural clinical placement. There are a number of factors influencing students' decisions to undertake a rural placement. For example, students who have lived and/or worked in small communities (Bushy & Leipert, 2005; Dobie, Carline, & Laskowski, 1997) and feel confident and competent (Edwards, Smith, Courtney, Finlayson, & Chapman, 2004) are more likely to choose a rural setting for their clinical placement. As well, exposure to the rural clinical setting during their educational program favorably predisposes students to consider pursuing a career in the rural setting upon graduation (Armitage & McMaster, 2000; McAllister, McEwan, Williams, & Frost, 1998; Neill & Taylor, 2002). That is, the positive and negative features of rural practice such as coping with issues of privacy and confidentiality while maintaining close community and family ties, working within a wide scope of practice with limited medical support, and taking on the responsibility of practicing autonomously are valued, and increase student insights into rural practice issues. However, students may question whether this type of clinical experience is worthwhile if they feel they are financially disadvantaged as a result of additional travel expenses, and the need to secure accommodation in the rural setting while undertaking a rural clinical placement. Therefore, they may be discouraged from pursuing such a learning experience unless financial assistance can be provided (Neill & Taylor, 2002). Nursing educators then must carefully design the coursework, plan the placement experience, and implement strategies that address those aspects of rural practice that are of most concern to students (Orpin & Gabriel, 2005) so that students' careers and personal goals and their undergraduate experience of rural practice are complementary.

Although factors influencing a student's choice of undertaking a rural placement have received considerable attention, like other preceptors, rural nurse preceptors benefit from learning and preparing for the preceptor role. For these nurses, attending a preceptor workshop provides them with greater knowledge, improves attitudes toward preceptoring students, and establishes greater consistency in organizational procedures related to preceptorship (Charleston & Goodwin, 2004). Adequately preparing rural preceptors also helps their understanding of preceptor boundaries and how to provide student support, and increases their problem-solving capacity (Mills, Lennon, & Francis, 2007). Rural medical practitioners concur that the opportunity to reflect on teaching practice results in preceptors becoming effective teachers for undergraduate students (Price, Miflin, Mudge, & Jackson, 1994). Preparation therefore, helps rural nursing preceptors keep their clinical knowledge up-to-date and enthusiastic about their role (Shannon, Walker-Jeffreys, Newbury, Cayetano, Brown, & Petkov, 2006).

Preceptorship and professional role socialization

Socialization enables nurses to become creators, shaping the meaning of the culture in order to transmit and transform their nursing culture (Colucciello, 2000). While socialization is intertwined with the development of a culture, professional socialization has been described as a process (Lum, 1978; Saarman, Freitas, Rapps, & Riegel, 1992; Tradewell, 1996) of acquiring the knowledge, skills, behaviors, attitudes, intellectual and emotional comfort, and the internalization of values that support an individual's transition into the professional role (Brief, Sell, Aldag, & Melone, 1979; Cohen, 1981). It includes the dimensions of moving from uncertainty and learning, to adjustment, culminating in gaining balance (Hart, 1991) suggesting professional role socialization occurs in stages

(Kramer & Schmalenberg, 1978; Cohen, 1981). However, the nature of the relationship between the preceptee and preceptor has a significant impact on the preceptee's understanding of his or her role, and job performance (Blau, 1988).

In nursing, professional socialization following graduation is one way to avert the disillusionment or "reality shock" (Kramer, 1974), and lack of job satisfaction experienced by beginning nurse practitioners. While Grinstead (1995) found newly graduated nurses who participated in a nurse externship program perceived that participating in such a program positively contributed to their professional socialization, Cantrell, Browne, and Lupinacci (2005) found there was no difference in job satisfaction and having a sense of belonging between registered nurses who did and did not participate in nurse externships. Unfortunately then, problems in the socialization process frequently result in disillusionment and dissatisfaction for beginning hospital staff nurses (Munro, 1983), resulting in high job turnover rates (Cohen, 1981). Although high job turnover rates in rural Australian hospitals do not seem to be a concern since many new graduates seek employment in rural hospitals because of their ties to the rural area related to partners, families, or financial commitments, these new graduates also frequently experience disillusionment and dissatisfaction because of: the hostile undercurrents that can prevail; staff shortages; and the increasing number of nurses who work in casual positions (Lea & Cruickshank, 2007). However, according to Wilson and Startup (1991) the turnover rate can be counteracted by good staff relationships and a favorable unit climate.

Mentorship versus preceptorship

It is necessary at this point for the sake of clarity, to differentiate between the concepts of preceptorship and mentorship because of the definitional inconsistency of these terms noted in the literature (Mills, Francis, & Bonner, 2008). Mentorship is generally an informal, long-term personal relationship that is likely initiated by one or both parties. This type of relationship is more orientated to career development, allowing the protégé to grow through personally managed learning experiences (Perry, 1988). Using similar characteristics, Stewart and Kruger (1996) have developed a definition of mentoring in *nursing* that has been widely accepted within the nursing literature (Mills, Francis, & Bonner, 2008). For these authors, "mentoring in nursing is viewed as a teaching –learning process for the socialization of nurse scholars and scientists and for proliferation of a body of professional knowledge" (Stewart & Kruger, 1996, p. 318). Mentoring also has the characteristics of occurring through personal experience within a one-to-one, reciprocal relationship between two individuals diverse in age, personality, life cycle, professional status, and/or credentials. The mentoring relationship generally lasts for a period of several years and may assist in career progression. To apply mentoring the clinical practice setting, Mills, Francis, and Bonner (2008) have amended this definition to include clinicians as potential mentees.

Preceptorships on the other hand, are constructed in response to specific learning needs of students in the clinical context. Unlike mentorship described by Stewart and Krueger (1996), preceptorships in undergraduate nursing programs are developed independent of learner characteristics, gender, age, or social class. They generally involve a number of individuals (students, preceptors, nursing educators, and agency administrators). The selection of preceptors varies across programs. Generally though,

preceptors are nurses who volunteer to take on the preceptor role. Preceptorships also include a certain amount of direct clinical supervision provided by the nurse preceptor. Although the student-preceptor relationship need not be personal, it may form a basis for collegial networking and future novice-nurse mentor contact. Thus, it becomes evident the terms preceptorship and mentorship are not entirely synonymous (Perry, 1988); however, they are frequently used interchangeably in the literature. Please note the terms are in the discussion on professional socialization are also used interchangeably.

The literature on professional socialization stresses the need for supportive structures for newcomers to enhance and facilitate their role transition (Makepeace, 1999; Thomka, 2001). In a synthesis of the literature on mentoring and academic success, Jacobi (1991) defined mentoring/preceptoring relationships as having three major components: providing emotional and psychosocial support, promoting professional development, and serving as a role model. As a consequence, the supportive nature of the preceptor/mentor relationship is perceived to have a positive influence on the personal and professional development of the preceptee, enhancing the quality of the preceptee's work life (Fields, 1991; Taylor, 1992). However, from the novice's perspective, the professional socialization that begins in their formal educational program is at times incongruent with the realities of the initial work environment. When the most important skill learned from their preceptor is time management, the poorly planned introduction of the novice practitioner to the professional experience can be psychologically traumatic and filled with disillusionment for them (Darby & Kasten, 1996). For professional socialization to be successful, preceptors need to clarify the professional role, teach problem solving and procedures, assist novice practitioners to develop a sense of

competence, and model the characteristic behaviors, attitudes, and values associated with the profession (Darby & Kasten, 1996).

Measuring the effectiveness of preceptorship

In nursing education, to measure the effect of the preceptored experience on the socialization of nursing students to the nurse role, various tools have been used. For example, using the Corwin's Nursing Role Conception Scale, Dobbs (1988) found the preceptorship experience was effective in promoting learning of the professional role prior to completing the educational program (anticipatory socialization) evidenced by changes in nursing students' role expectations and self-image and a decrease in perceived role deprivation. Clayton, Broome and Ellis (1989) used Schwerian's Six Dimension Scale of Nursing Performance and found the transition to staff nurse by preceptored students was more effective than nonpreceptored students. Preceptored students tended to score higher than nonpreceptored students on the subscales of leadership, teaching/collaboration, interpersonal relations and communication, as well as planning and evaluation. Consequently, one of the benefits of the preceptored experience for nursing students, regardless of the type of nursing program (diploma, baccalaureate, or bridging program Registered Nurse to Baccalaureate educated nurse), has been the easing of the role transition from student to graduate nurse (Goldenburg & Iwasiw, 1993). Because nurse researchers are uncertain when socialization occurs for nursing students, if it occurs in the classroom, in the clinical setting, or both (Chun-Heung & French, 1997; Olsson & Gullberg, 1991), or indeed if professionalism is affected by academic progression (Colucciello, 1990), more research is needed to determine the impact preceptorship has on nursing students' professional socialization.

Nursing educators are advised that, if at all possible, only one preceptor should be assigned to individual students, since students working with multiple preceptors have greater role discrepancy than students working with a single preceptor (Ullrich, 1997). Indeed, the impact that preceptors have on nursing students' professional socialization is pivotal. Preceptors that take time to nurture the relationship with their students in its initial stage by developing a safe learning environment, provide encouragement, information and feedback, facilitate student self-confidence and independent practice (Crawford, Dresen, & Tschikota, 2000).

Role socialization and the clinical placement

The clinical setting is an important factor affecting nursing students' professional socialization, since it is the most influential factor in the development of students' nursing skills, knowledge and professional socialization (Chun-Heung & French, 1997). However, it is often times overlooked. Therefore, although students value the clinical placement for learning and work to fit into the environment, they may in fact act in ways that are not consistent with what they learned in the classroom regarding professionalism (Grealish & Trevitt, 2005). This inconsistency in behavior might exist because professional socialization has been found to be marked by implicit rather than by explicit factors (Thompson, 1996). To help ease this discrepancy, registered nurses could engage in behaviors such as sharing reasoning processes and belief systems guiding their practice, demonstrating how to communicate within the health care setting, and encouraging students to talk about power issues they become aware of in the clinical setting, to make explicit the process of professional socialization (Thompson, 1996).

Another implicit factor that affects professional socialization is nursing students' professional and social acceptance into a community of practice (Cope, Cuthbertson, & Stoddart, 2000). For students, becoming a nurse is as much about joining a community of practice represented by qualified nurses as it is about learning the technical skills of nursing practice. While the use of cognitive apprenticeship techniques such as modeling, coaching, scaffolding of learning experience, and incremental independence provide students with a sense of professional acceptance, students feel vulnerable. Therefore, social support and reassurance is an essential part of their professional socialization (Cope, Cuthbertson, & Stoddart, 2000). Thus, although student cognitive ability and role-taking propensity have a significant impact on student perception of the professional self (Brakey, 1999), nursing students need supportive structures to enhance and facilitate their professional socialization and role transition. The interplay between the placement experience and the professional socialization of nursing students is a fundamental aspect of nursing education.

In summary, several themes emerged from this literature review. First, preceptorships have been examined in an effort to determine if they facilitate effective nursing student learning, the development of critical thinking skills, and clinical competence. Second, research examining rural hospital preceptorships has been limited to the exploration of factors influencing students' choice in selecting a rural placement, and the impact attending an orientation has on rural preceptors. Third, to determine the effectiveness of the preceptored experience on the socialization of nursing students to the professional nurse role, various measurement tools have been used. However, the impact preceptorship has on nursing students' professional socialization remains unclear. As

well, the interplay between the placement experience and the professional socialization of nursing students continues to be poorly understood. The purpose of this study is to describe the experience of rural hospital nurse preceptors and nursing students during a preceptorship experience so that we can begin to understand the interaction between the rural hospital setting, and nursing student professional socialization. Through this understanding, rural preceptorships can become a more effective teaching strategy in nursing education. The broad research question that guided the study was, "What are the experiences and perceptions of undergraduate nursing students and nurse preceptors during a rural hospital preceptorship?"

Note: In the following chapters, you will note a stylistic change in my writing. In order for you to see the lives of the people I have studied as they see themselves (Spradley, 1979), I have attempted to bring their culture to life by presenting specific incidents and experiences. To achieve this goal, a more narrative style of writing seemed appropriate and I believe has allowed me to help you see what is happening in a rural hospital preceptorship and perhaps even feel the things that the preceptors and nursing students felt during their experience.

CHAPTER THREE
METHOD

The purpose of this project was to describe the experience of preceptors and fourth year nursing students during a rural hospital preceptorship. I chose to conduct a focused ethnography because this method is best able to investigate the behaviors and beliefs for their meaning among rural hospital preceptors and undergraduate nursing students during a preceptorship experience (Boyle, 1994; Morse & Richards, 2002; Muecke, 1994). This method was also best suited to examine the experience of undergraduate nursing students and rural preceptors who were geographically dispersed and linked by their experience and not by geography. Furthermore, since some of the everyday behaviors that represent the culture of a rural hospital preceptorship could be identified (Leedy & Ormrod, 2005), both explicit, and tacit aspects of the preceptorship experience could also be investigated for their meaning.

Having chosen to conduct the project using a focused ethnography approach, there are significant differences to note between a traditional ethnography and a focused ethnography. Focused ethnographies are time-limited and topic specific (Robinson Wolf, 2007). Data making for this study was conducted during the ten week preceptored clinical experience in the students' senior year.

Data making in a focused ethnography might include only some of the strategies used in traditional ethnographies, and may give primacy to a particular data making strategy (Morse & Richards, 2002). For this study, semistructured interviews were the primary strategy for data making. Although my intent was to supplement interviews with relatively short term field visits (Knoblauch, 2005), because both the preceptors and students expressed some unease with being observed during hospital visits, field visits for

the purpose of participant observation did not occur. In lieu of this, a focus group interview was conducted. One student journal and my field notes rounded out the data making strategies used for this project.

Like any other qualitative study, data making and analysis occurred simultaneously (Morse & Richards, 2002). Since the aim of the data making was to portray the culture of a rural hospital preceptorship (Robinson Wolf, 2007), the steps for ethnographic analysis described by Spradley (1979) were used. Typical of ethnographies, data analysis was time and energy intensive (Robertson & Boyle, 1984).

Setting

The geographical setting for this project was rural central and northern Alberta and the Yukon, Canada. Although there is no universally agreed upon definition of the term "rural" in the literature, duPlessis, Beshiri and Bollman (2001) define rural as "the population living in towns and municipalities outside the commuting zone of large urban centers [with] populations of 10,000 people or more" (p.1). The term rural might also be defined as referring to those areas in which access to health care services is limited due to distance and the lack of qualified health professionals (Romanow, 2002; Pitblado et al., 1999). Unique characteristics that include not only demographic and geographical data but as well, social, economical, and political factors influence one's perception of "being rural." For this study, the participants identified themselves as "going rural," were geographically dispersed over a 640,000 square kilometer area, and located in 11 communities with populations ranging from 1,800 to 15,000 people. All but two communities had populations of less than 10,000 people. The two larger communities had populations between 11,000 and 15,000 people.

The rural hospitals within these communities were generally able to offer only a limited number of clinical placements for nursing students. There are several reasons for this including the limited number of registered nurses willing and/or able to take on the preceptor role, physically smaller patient care units and fewer patients, and at times more limited learning experiences. In this study, the smallest hospital had 20 inpatient beds and the largest had 72 beds. Most of the hospitals had between 20 and 30 inpatient beds. All of the hospitals had a small complement of staff. Only three hospitals were able to host more than one student at a time for the preceptorship. A few of the hospitals also had other types of learners in the facility at the time of the preceptorship experience. Thus, a variety of hospitals hosted the participants in this study. As a consequence of having a variety of hospitals as the context for the students' preceptored experience, descriptive details of one particular rural hospital setting was lost. However, the object of this study was not to describe *a* particular rural hospital setting and *all* of its culture, but rather, the professional socialization of senior nursing students during their preceptored rural hospital clinical experience (Nadai & Maeder, 2005).

Sample

Since the aim in qualitative research is to understand the phenomenon of interest, purposive sampling was used (Glaser, 1978). To achieve purposive sampling, inclusion criteria included: fourth year baccalaureate nursing students undertaking the final senior preceptored clinical experience in a rural hospital, and were are able and willing to reflect and articulate their experience; and preceptors and nursing instructors teaching fourth year nursing students during the senior, preceptored experience in a rural hospital. I felt

these criteria would help me find participants that would provide the greatest opportunities to gather the most relevant data (Germain, 2001).

The student participants in this study were recruited from a large western Canadian university and two of its affiliated colleges. An information letter (Appendix B) was sent to all the baccalaureate nursing students in these three educational facilities who were undertaking their senior preceptorship in a rural hospital. I did not know these nursing students, so they could feel free to decline to participate. The information letter was forwarded to all potential participants by the clinical coordinators or their designate, while they were taking the theoretical course (Nursing 494) that preceded the preceptorship (Nursing 495). Unfortunately, this particular strategy was unsuccessful in recruiting potential participants who were to complete their preceptorship in the fall session (2006). As a result of failing to recruit potential participants, my recruiting strategy was modified. After notifying the university's human research ethics board of a new recruitment strategy plan, I negotiated with the appropriate year coordinators and nursing instructors to conduct a presentation of my study to all of the students enrolled in the winter session (2007) of Nursing 494. Two of these presentations were conducted outside of scheduled class time while one presentation was incorporated into classroom activities. At the end of the presentation, students were invited to speak with me directly or contact me via email. Six students were recruited in this manner. Preceptors received an information letter inviting them to participate in the study (Appendix B) from the student participants at the beginning of the preceptorship. Three preceptors volunteered to participate in the study.

As a second recruiting strategy, former students and preceptors who had completed a rural hospital preceptorship within two years from the beginning of this study received an information letter via email from clinical placement coordinators (Appendix C). Two students and two preceptors were recruited using this approach. The remaining participants were referred to me by other participants or nurses through the use of a word-of-mouth snowball technique.

Once the potential participants had contacted me either in person or via email of their interest in participating in the study, I followed up with a telephone call. At that time I answered any questions they had, assessed their ability to articulate their thoughts, and arranged a date and time for the first interview. It was during this initial discussion that it became apparent the participants felt uneasy with participant observation. Although the purpose of participant observation was explained, they remained uneasy with this portion of the study. Since focused ethnography does permit the use of a primary data making strategy, I reassured the participants that engaging in participant observation was not a condition for participating in the study. With this reassurance, all participants were eager to be interviewed.

To recruit nursing instructors, an information letter was sent to those nursing instructors whose students were scheduled to undertake a rural clinical experience (Appendix D). These were forwarded by the clinical coordinators via email. The purpose of sending information letters to nursing instructors was twofold: to raise students' awareness of the study by having the instructors talk to them about the study and, to get the nursing instructors to consider participating in the study themselves. Although supervising nursing instructors were invited to participate on two different occasions,

none of them accepted the invitation. The last recruitment strategy I used was to display a large poster on the information bulletin board outside of the undergraduate nursing office (Appendix F).

Generally less than one-sixth of the students in the senior nursing class will choose a rural hospital placement (M. Bazin, Coordinator of clinical placements, personal communication, January, 2006). Of the 15 students who were completing the final clinical course, Nursing 495, in the fall session, only two students undertook a rural hospital preceptorship. In the winter session approximately 30 students from the three educational institutions undertook a rural hospital preceptorship. As a consequence there were a limited number of potential participants for this study. The final sample size for this study was 12 nursing students and six preceptors. Six students and three preceptors were undertaking their preceptorship during the study, and six students and three preceptors had completed the preceptorship experience within the last two years of the start of this study.

Eleven students were female and one student was male. Their ages ranged from 21 to 36 years with the majority of participants being in their mid-twenties. Most of the students in this study originated from or grew up in smaller towns, and either had accommodation in town or they were able to commute on a daily basis to the clinical site. While some students chose to return to their "home" town with family living in or near the town, other students chose a rural hospital at long distances from their place of residence. Some students had previous experience working in either the hospital designated for their preceptorship, or in some other small rural hospital as an undergraduate nursing student employee. For these reasons, most of the students in this

study had some knowledge of what small towns were like having either lived and/or worked in small rural towns.

Five preceptors were female and one preceptor was male. They ranged in age from 27 to 51 years. The number of years as a registered nurse for the preceptors ranged from three to 31 years, and all but one participant had previous experience preceptoring nursing students. All of the preceptors lived within the rural community in which the hospital was located.

Generation of Data

As noted earlier, in a focused ethnography, primacy is given to a particular data generating strategy: therefore, data making may include only some of the strategies that define ethnography (Morse & Richards, 2002). In this study, the generation of data occurred primarily through interviews. Nursing students were also asked to journal their thoughts, feelings, and experiences. Conducting a focus group interview was a third strategy for generating data. Field notes were written after each individual interview and following the focus group session.

Interviews

The ethnographic interview has been described as a series of friendly conversations (Spradley, 1979) and contains less structure than in the use of formalized open-ended questions (Germain, 2001). Because I had preexisting knowledge of the clinical setting, the interview stayed within preestablished general guidelines (Evaneshko & Kay, 1982). However, I kept to the stylistic elements of an ethnographic interview (Spradley, 1979). Thus, I began each interview by clarifying the purpose of the interview.

At this time I also answered the participants' questions and provided explanations if he or she was unsure of what to expect during the interview.

Once the purpose and process of the interview were explained and I had gathered the participants' demographic information, the interview proceeded by introducing a number of questions that were sequenced and paced according to the conversation (Sorrell & Redmond, 1995). For example, I began each interview with a "grand tour" question such as, "Describe what the rural hospital experience is like for you." As the interview proceeded, I asked questions that provided more specific cultural information such as "What was it like being a student in a rural hospital?" or, "How do ties to the community and its members impact the type of nursing care provided?" The last type of question I used helped discover the meanings of words that the participants used to describe their culture by finding similarities and differences in how they saw the words. For example, I asked the participants to describe a typical shift and atypical shift. Subsequent interviews were guided by the emerging domains and taxonomies, and so I took more control of the process, and questions became more explicit. The interview guide I used can be found in Appendix G.

A total of 24 interviews were conducted. Six interviews were inperson face-to-face, ten interviews were conducted via telephone, and eight interviews were conducted using videoconferencing technology. All of the interviews lasted as long as the participant had something to share about their experience. Generally, the first interview lasted two to two and one half hours, and the second interview lasted one to two hours.

Inperson interviews were conducted at a mutually convenient time and place; some interviews were conducted outside the hospital, while others were conducted within the hospital, generally the board room or library.

The use of the telephone and videoconferencing technology was not originally planned for, however, because of weather conditions, (a 30-year record snow fall occurred during the course of the study) and subsequent travel considerations, three quarters of the total number of interviews were conducted using these technologies. While there are varying points of view regarding the advisability and utility of using these technologies to conduct research interviews (Musselwhite, Cuff, McGregor, & King, 2007), they were an effective mechanism for data making because they were economical and my time was used efficiently. When I was unable to travel to the participants' community or I was unsuccessful in booking the videoconferencing technology, I notified the participant as soon as possible. Consequently, I believe the participants felt that I was sincerely interested in learning about their experience and so they were open to telephone interviews when I was unable to interview them face-to-face. Furthermore, I feel that I was able to develop a positive relationship with the participants that yielded rich data. The use of the telephone did not preclude the use of the stylistic elements of the ethnographic interview or researcher reflexivity (Robinson Wolf, 2007). Although interviewing via telephone did not allow me to observe the participant's facial expressions or body movements, because it was convenient and conducted at a mutually convenient time and place, (all of the participants choose to have the telephone call placed to their home phone number) they expressed satisfaction with this data making technique.

Interviews conducted via videoconference were negotiated based on availability of the technology from the participants and researcher's home sites, as well as our individual availability. The availability of the videoconferencing equipment was on occasion problematic since in many of the hospitals, priority usage of the equipment was given to meetings that pertained to direct patient care. Therefore, meetings between consulting professionals received priority while meetings for research purposes were booked only if no other meetings had been scheduled.

All interviews were conducted outside of the students and preceptors' scheduled work time. Furthermore, five students and one preceptor were asked for a follow up interview to help clarify information, fill in the gaps, and answer additional questions that arose from the analysis.

Lastly, since I had made the assumption that it would take both the student and preceptor some time to become familiar with the rural setting and the learning experience within that setting, the first interview with each participant was scheduled no earlier than four weeks into the clinical experience. Frequently, they were scheduled at about the five week mark. The second interview was scheduled when the students and preceptor had completed the experience.

Journaling

For this study, nursing students were invited to record their thoughts, feelings, and experiences throughout the preceptored clinical experience. Only one student sent me the journal that made up part of the requirements of the course. This journal was analyzed in the same way as data arising from interviews.

Focus group

Focus groups can help researchers better understand how or why people hold certain beliefs about a topic of interest (Maykut & Morehouse, 1994), and so can be used to supplement data generated in a research project (Subramony, Lindsay, Middlebrook, & Fosse, 2002). Since I was unable to engage in participant observation, purposefully bringing together a group of staff members to discuss the experience of having nursing student preceptoring in their rural hospital was an alternate way for me to gather valuable information from the most knowledgeable, and experienced key players in the facility. This group however, varied from Krueger's criteria (1998) where group members should be unfamiliar with each other. These group members knew each other extremely well since they not only worked together, but they also lived in the same rural community and so knew each other outside of the work environment.

To gain access to a group of staff members, I contacted a former rural hospital preceptor, a gatekeeper (Robinson Wolf, 2007), who was well known to me. I explained the purpose of the meeting, generally how the meeting would unfold, and who was eligible to attend the meeting should they wish. A date, time, and place for the meeting were selected. The former preceptor and I then discussed how best to proceed with inviting staff members to participate. It was decided that I would need the hospital administrator's support in order for this meeting to take place. The preceptor spoke with the administrator who took on the responsibility of "advertising" to all staff members the opportunity to participate in the focus group. The administrator also booked the room for the meeting.

Three registered nurses, all of whom were experienced preceptors and who were known to me, a physiotherapist, and the hospital administrator made up the participants

for the focus group. Both the physiotherapist and hospital administrator also had previous experience preceptoring students. Although I was initially concerned that the group members might not feel comfortable sharing with me their thoughts and feelings because of the hospital administrator's presence in the group, the group displayed cohesion and camaraderie amongst themselves typical of a rural hospital staff. Hence, I felt the group members did not feel restricted by the administrator's presence.

Prior to the start of the session, I introduced myself and gave a brief description of how I came to be seated with them at the meeting. I asked each member to share with me their name, position within the hospital, and whether they had previously preceptored a student. Before turning the tape-recorder on, I explained to them that the session would be recorded and transcribed verbatim by me. I also explained that they were free to decline answering any question I asked, and that they could leave the session at any time without consequence. So that they could feel comfortable sharing their experiences with me without fear of being recognized, I explained the strategies I would use to protect their identity: they would all be assigned initials, and all identifying information regarding themselves, other staff members, patients and their families, the hospital, and community would either be removed or changed. Lastly, I confirmed with each member that their presence at the meeting indicated their consent to participate in the study.

To help the group focus on the task at hand, I explained to them the focus group process as well as the purpose of the session. Although it would have been preferable to have a second moderator present to observe the interactions between group members, which would then be added to the data set (Agar & MacDonald, 1995), the rural location and timing of the session made it difficult to bring an observer. To compensate for the

lack of having an observer during the session, as soon as the session was finished, I wrote my observations in my field notes.

Once all their questions were answered and every member was comfortably seated so that they could easily see each other, I began by asking the open-ended question "What's the meaning of preceptorship for you?" Although I had five or six prepared questions to guide the discussion, the discussion was lively: turns were at times short and sometimes one group member would dominate the discussion (Agar & MacDonald, 1995). At these times, I would have to direct questions to specific members in order to check with them if what was being said fit with their own experiences and feelings. Often times group members would discuss amongst themselves particular experiences. On one particular occasion the group shared a "folk model" (Agar & MacDonald, 1995) pertaining to "students that don't get it." At this point some explanation was required so that I could understand their experience. Following the transcription of the session, the transcript became part of the interview data set and analyzed in the same fashion as the other interviews.

Field notes

Field notes were written as soon as possible after every interview. I recorded how the interview took place that is: inperson, via telephone, or through videoconference. After the inperson or videoconference interview was finished, I described the setting to the best of my ability. I also described what the participants looked like and how they used their physical space. Lastly, I described my reactions and feelings about the interview as well as any questions the interview produced for me. In this way, reflexivity (Robinson Wolf, 2007), or the tension between being the researcher and becoming a

member of the culture was articulated, as well as how I as "instrument" affected the direction and focus of data making.

Data Analysis

Since the goal of data analysis is to provide a rich, detailed description of the culture, data making and analysis proceeded simultaneously (Germain, 2001; Morse & Richards, 2002). To begin the process of analysis, as soon as possible after the interview, I transcribed the interview. Each transcription was formatted using a table with four columns. Each time someone spoke, a new row was added to the table. Once I had finished transcribing the interview, I "cleaned" the data by checking for accuracy, italicizing or bolding words for emphasis, and inserting in the appropriate places paralinguistic features I had recorded in my field notes. For example, one participant was at times visibly distraught during the interview. When I reviewed this transcript I inserted the paralinguistic features such as whispering and crying in the appropriate places. Lastly, all personal identifying information was removed, and each participant was assigned a numerical code. Identifying information related to other staff members, patients, the community, hospital setting, or well-known events were changed in order to protect the anonymity of the residents who worked and lived in the community.

For data management I used several functions embedded in the *Microsoft Office Word 2003* processing program. I created separate electronic folders for each stage of the research process: one each for interviews, theoretical memos, theoretical analysis, demographic information, audit trail, narrative, and student journals. Within these folders were files that grouped relevant data together in various ways.

So that the system of cultural meaning students and preceptors used during a rural hospital preceptorship could be uncovered, I used four kinds of ethnographic analysis: domain analysis, taxonomic analysis, componential analysis, and theme analysis (Spradley, 1979). To conduct a domain analysis I first reviewed the whole transcript, highlighting and bolding key words and phrases. Then, proceeding line by line and using *Word*'s comment function, I copied and pasted codes or inserted coding comments in a column on the right hand side. As part of my analysis, any questions or comments were added to the last column on the right hand side of the table. As the coding of transcripts proceeded I began to insert category labels in this last column.

As I worked, I would often scroll up or down the transcript to compare codes. I would also open other interview documents to compare codes across multiple interviews. Once I had electronically coded the data, I would make a hard copy of the transcript and study the manuscript making more handwritten analytical notes to group fragments of data into substantive categories. To help me understand what was going on and to create categories, I would cluster the codes in such a way that a summary could be written up. Each category was then arranged in such a way as to represent a domain. Sometimes pieces of data would fit into more than one category, showing the rich complexity of the participants' experiences. I would then compare data within and between transcripts for ongoing coding and concept formation, development, modification, and integration. I then re-sorted the data that I had placed in each of the original substantive domains. At this point in my analysis, four domains were identified: "Life in "Dog River"; "Dog River" Community Hospital: Grey's Anatomy it's not!"; "Dog River": A great

placement!"; and, "I belong in "Dog River". Categories associated with each of these domains were also identified.

Representing the Data

My goal in this ethnographic study was to provide a rich detailed description of preceptors and nursing students' experiences and perceptions of a rural hospital preceptorship. Because there is a well developed body of research on preceptorship, I wanted to focus my writing on the unique findings of this study. In my first attempt at describing their experience, I used an academic style of writing in which I described a category, followed by a quote. However, I felt that this style did not communicate the cultural meanings (Spradley, 1979) I had discovered in a way that would bring them to life for any reader who might be unfamiliar with the rural setting and the rural hospital setting. This difficulty led me to consider how I might represent the data so that you could connect to the participants' experiences. As a result, I was drawn to the popular Canadian television comedy *"Corner Gas,"* and its town of "Dog River" as a metaphor for my central themes in my data analysis. This metaphor however extended only to encompass what it might be like living in a small community where everybody knows everybody, and to display the complex web of relationships rural residents' experience. Extrapolation of this metaphor beyond the concepts of belonging and relationships is inappropriate. For example I recognize that some aspects of the television program *"Corner Gas,"* such as being in a small and declining community are not reflected in the rapidly expanding communities of my participants' experience.

Having said this, as the participants in this study were describing their experiences of living in a small rural community, the data seemed to reflect some of the

experiences of the characters in the television program *"Corner Gas."* The first domain then came to be labeled "Life in "Dog River." Since there is no local hospital in "Dog River," I decided to create an imaginary rural community hospital to represent what the participants were telling me about the rural hospital setting. Thus, the second domain came to be labeled "Dog River" Community Hospital: Grey's Anatomy it's not!" The third domain,"Dog River": A great placement!" reflects the meaning students and preceptors give to preceptorship and how they prepared for the experience. The fourth and last domain, "I Belong in "Dog River," captures the students and preceptors experiences of what happens during the preceptorship.

Once the surface structure analysis was completed, I constructed a taxonomy for each domain that can be found at the end of this chapter. Using an index for each category within the domain, subsets of symbols for each category along with the relationships between these symbols became evident thereby providing me a holistic picture of the culture (Spradley, 1979). For example the taxonomy for the domain labeled "Life in "Dog River" consisted of: population growth; health care services; physical isolation; emotional isolation; and, outsiders are outsiders. Throughout this process I continually asked myself what was the meaning of preceptorship experience for the students and preceptors.

By using contrast questions such as, "What different types of isolation might you experience living in a small rural town?" I was able to organize the participant's information in such a way that the attributes associated with each symbol were identified (Spradley, 1979). For example, participants discussed the attributes of isolation as: being able to leave, physical distance, activities, being able to connect with others, and health

care. The goal of componential analysis, however, is to identify multiple relationships between symbols: that is, to map as accurately as possible the participant's psychosocial reality of their cultural knowledge (Spradley, 1979). Therefore, other symbols within the taxonomy labeled "Life in "Dog River" were analyzed for their attributes. Analyzing all the symbols and their attributes created a paradigm that began to illustrate the relationships between symbols.

In an attempt to discover the conceptual theme the participants of this study used to connect the domains, "Life in "Dog River"; "Dog River" Community Hospital: Grey's Anatomy it's not!"; "Dog River": A great placement!"; and, "I Belong in "Dog River," I searched for a tacit or explicit cognitive principle that was recurrent and that served as a relationship among the paradigms and contrast sets (Spradley, 1979). The cognitive principle about the nature of their experience of a rural hospital preceptorship for the participants in this study seemed to revolve around "the sense of belonging."

To achieve a "thick" description, as a final step in the data analysis, my own observations and the experiences of the participants were linked to the existing literature and theories so that generalization, validity, and abstraction was achieved (Morse & Richards, 2002).

Verification Strategies for Establishing Reliability and Validity

As suggested by Morse, Barrett, Mayan, Olson, and Spiers (2002), I attempted to establish rigor throughout the processes of conducting this project. These authors define rigor as a process that is self-correcting, iterative so that the researcher moves back and forth between the design and implementation, and where data are systematically checked and the interpretation of the data is monitored and constantly confirmed. Verification

strategies used during this study that helped to ensure the reliability and validity, and thus the rigor of the study, included investigator responsiveness, methodological coherence, sample appropriateness, concurrent data making and analysis, theoretical thinking and theory development.

Investigator responsiveness

Investigator responsiveness is described by Morse, Barrett, Mayan, Olson, and Spiers (2002), as the researcher's creativity, sensitivity, flexibility, and skill in using the verification strategies presented in this section. Asking analytical questions such as "What makes the experience of a rural hospital preceptorship in some situations less positive or successful than in others?" I was able to use purposive sampling. For example, I sought out a student who had a less positive rural hospital preceptorship experience so that data saturation could be achieved. I also remained open, used sensitivity, creativity and insight, and was willing to let go of any ideas that were poorly supported. For example, initially I believed this study was mainly about "building bridges." By remaining open and sensitive, in the end I was able to identify the cultural theme "a sense of belonging" as the cognitive principle that connected all of the domains. Lastly, to ensure investigator responsiveness, before data generation began, I wrote my own story about preceptorship. By writing what my own experience had been with students during a rural hospital preceptorship, my feelings and biases were articulated, subsequently increasing my awareness of their existence.

A strategy that demonstrates responsiveness when the data do not appear to be as useful as they should be is to consider why the data are not fruitful (Morse & Richards, 2002). Strategies for the generation of data might then need to be reconsidered and

changed. Although I had invited all student participants to journal about their experience, only one student accepted this invitation. Using this data making strategy therefore, was not as fruitful as I had hoped.

A final strategy that helped to ensure investigator responsiveness, especially given that I am a novice researcher, was to work closely with my thesis advisors. Soliciting and incorporating their feedback helped prevent the problems of not listening to the data, being unable to abstract, synthesize or move beyond coding data, or working deductively rather than inductively.

Methodological coherence

Methodological coherence is defined as the congruence between the research question, the theoretical and philosophical assumptions, and the components of the method. To help achieve methodological coherence between these components, I used the naturalist/interpretor perspective as a lens to guide data making and analysis, thereby providing this project with a particular focus (Morse & Richards, 2002).

In keeping with the purpose of this focused ethnography, the professional socialization of nursing students within the context of the rural hospital setting was investigated. The broad research question that guided the study, "What are the experiences and perceptions of undergraduate nursing students and nurse preceptors during a rural hospital preceptorship?" was congruent with the purpose of this focused ethnography.

Data generation strategies of conducting semistructured interviews, journaling, conducting a focus group, and writing field notes were also congruent with a focused ethnography approach. These strategies also reflected the naturalist/interpretor

framework where multiple realities were expressed. This was especially evident in the focus group.

To further maintain methodological coherence I deliberately created recruiting strategies where the participants would identify themselves as "going rural" rather than imposing on the sample a predetermined definition of rural. Thus, the participants recognized something in their "reality" as being reflective of being rural.

Lastly, because ethnography is inquiry that is value-bound, manipulation of participants was minimized. I was able to be responsive to the information and cues given by the participants therefore, our interactions became inseparable. Furthermore, since qualitative researchers limit a priori knowledge and attempt to develop genuine relationships with the participants (Lipson, 1991), I became the primary tool for the generation of data. To become more aware of how my own personality, cultural background, and use of self affected the field of study, field notes were kept. Further, I attempted to identify the assumptions I held pertaining to nursing students, preceptorship, and the rural hospital setting before starting the project.

Appropriateness of sampling

Appropriateness of sampling meant that participants who best represented or had knowledge of the research topic were invited to participate in the study using the inclusion criteria as described above. Because the number of potential participants was small, former nursing students and preceptors who had completed a rural hospital preceptorship were included in the study. Other sampling procedures that were used included snowballing (one participant recommended two other persons to be invited to

participate) and convenience sampling (one participant was recruited while visiting another participant).

So sampling adequacy, a second component of appropriateness of sampling, could be achieved, sufficient data to account for all aspects of the phenomenon had to be obtained. As data analysis proceeded, theoretical sampling was used by deliberately seeking out persons to participate according to the emerging theoretical scheme. Using the sample size from other qualitative studies as a guideline, the number of participants for this study was 12 nursing students and six preceptors. As previously indicated, no nursing instructors volunteered to participate. As the interviews proceeded, I was able to "focus" my interview question(s) so that data generated supported or refuted my developing theoretical understanding. For example, one preceptor spoke of "protecting" the student. In subsequent interviews, I asked not only preceptors but students as well, about the concept of "protecting."

Data gathering continued until each category was rich and thick, and until no new data were generated. At this point, data saturation was reached. One way I verified that data had been saturated was to go back to the literature and read reports that discussed rural hospital preceptorships to see if any new questions would arise, and to verify that events did not represent a single instance but that they were replicated in several cases. By using this strategy I was able to verify that "protecting the student" was in fact reported in the literature.

The final strategy for ensuring appropriateness of the sample was to seek out a student who had a different experienced of the rural hospital preceptorship so that all data could be accounted for. When I identified instances when what the participants were

saying was different from what the majority of the participants shared, I reread and continued to analyze not only that particular transcript but other transcripts as well. To ensure I had understood what the participants' experiences were like and what they meant, I interviewed five students twice and one preceptor once.

Generating and analyzing data concurrently

In generating and analyzing data concurrently, before conducting an interview with a new participant, I tried to transcribe and begin the analysis of the transcript from the previous interview. This strategy helped to increase my understanding of what was happening, and helped to focus the upcoming interview. Although I was able to transcribe and begin analysis prior to conducting another interview on most occasions, there were times when interviews were clustered and I was unable to transcribe the interviews. At these times, I would listen to the whole or parts of the yet transcribed interview and review the notes and questions I had made during the interview.

To systematically order the data, all interview transcripts were dated, as well as field observations, field notes, and journal entries. To help monitor changes and rationale for any adaptations in methodological approach such as the data-driven refinement of the interview questions and field observations, field notes were kept. To keep track of coding decisions, I used a theoretical memos file in *Word* to track changes in the development of categories, coding, and relabeling of categories. These changes were also hand written in the hard copy for each category.

Thinking theoretically

In thinking theoretically, ideas that emerged from the data were reconfirmed in new data (Mayan, 2001), and the extant literature. I moved from the raw data to more

abstract theoretical understandings that generated new ideas that were then verified in data already collected. Thus, by using the steps for ethnographic analysis (Spradley, 1979), I was able to create paradigms. These paradigms moved my thinking from the descriptive level to the theoretical level. Lastly, by consulting with my supervisors, focusing on, and continuously rechecking the data, I believe my theoretical thinking and interpretations of the data captured the professional socialization experience of nursing students undertaking a rural hospital preceptorship.

Theory development

For theory development to occur, I had to capture the story line across all the participants' experiences (macro perspective) keeping in mind that although the participants' subjective meanings were verified, the basis for drawing cultural inferences were my interpretations of the meanings communicated by the participants. Once I had written the "results" chapter that included my interpretation of the students and preceptors' experiences of a rural hospital preceptorship, I asked a former student who had recently completed her preceptorship in a rural hospital to read and comment on my findings and interpretations. She indicated that the story line "resonated" for her, thereby providing me with support that my interpretation of the meaning of the experience was accurate.

As the final step in ensuring validity, I compared my findings with the literature. Although there were some new findings in my work, the majority of my findings fit with the extant literature.

Ethical Considerations

This proposal was submitted for ethical review by the Health Research Ethics Board at the University of Alberta. (See appendix A for the letter of approval). Before I begin discussing the main ethical considerations within this report which are informed consent, confidentiality, and anonymity, I have outlined some of my own beliefs and their implications for the conduct of ethical research. First, I believe the therapeutic imperative of nursing (advocating for safe patient care, safe nursing practice environments, and advocating for nurses) takes precedence over the research imperative of advancing knowledge should a conflict arise. Second, I believe research participants collaborate in the research enterprise: they are participants, not objects or subjects. As well, I believe the term "informed consent" is static. Because there may be unforeseeable events and consequences while conducting a study, a static term for consent is not appropriate. Rather, to protect the participants' human rights, their consent must be negotiated and renegotiated to reflect the dynamic nature of qualitative research. Last, so that fieldwork (interviewing and observation) is existential and authentic, there must be trust between me and the participants. Although as a researcher, I invited participants to participate in the study, being "allowed" into the participants' world is a privilege.

Informed Consent

Information that I provided to the participants for the purpose of obtaining informed consent included the title, purpose, explanation of the research and the procedures that would be followed. Although I did not have any direct connection with the participants, I am a nursing instructor working in a program that is in collaboration with the university from which some of the participants were to be recruited. Therefore, I shared with the participants my status as a nursing instructor. However, because I was not

directly supervising any of the nursing students or preceptors, I reminded them that I did not have any influence over their academic progression or employment status. Signed consent forms (Appendix E) were required prior to the first interview. These were often faxed to me or presented to me just before beginning the first interview. Included in the form was a statement that the participant would have an opportunity to ask questions, and that he or she would be free to withdraw from the study at any time without academic or employment consequence (Field & Morse, 1985). Many of the participants did ask questions before and at the end of the interview. I answered all of their questions as completely as I could, and invited them to call me or send me an email with any further questions.

Although there were no known discomforts or risks associated with participating in this study, one participant did recount experiences that were visibly upsetting for her. During these times I would stop the tape-recorder, provide tissue, and give the participant time to re-gain her composure. Before turning the tape recorder back on, I would confirm with her that she was able to continue. Each time this happened the participant indicated her willingness to continue with the interview. At the end of her interview, she thanked me and said that it felt "good" to finally talk about her experience without worrying about how it might sound. In follow-up emails with this particular participant, no lasting distress was noted.

From this example, it is evident that informed consent was an ongoing process (Munhall, 2001). Indeed it was renegotiated as unexpected events arose. It was also renegotiated prior to interviewing participants a second time. Although it is written in the consent form that participants are free to withdraw from the study at any time and that

they can refuse to answer any question without having to provide a reason, these rights were reiterated at the beginning of each interview. On one occasion I felt the participant was hesitant in sharing information she felt was sensitive. I reminded her of her right to refuse to answer, however she chose to provide me with an answer.

Although I had explained the purpose of participant observation, both preceptors and students felt uneasy with having me observe them for a period of time. Having participants feel uneasy with participant observation that is generally a strategy for data generation in a focused ethnography, presented me with an unforeseen challenge. To remain ethical, I assessed the effects of my involvement in the field, and subsequently choose to conduct a focus group interview in lieu of engaging in participant observation.

Confidentiality

Another area that needs ethical consideration in fieldwork which includes interviews and observations is confidentiality. Data in this study included all communications with the participants. When on one occasion the participant expressed concern with how her grade for the course would be determined, I suggested she contact her nursing instructor for this information. Since I believed how the grade for the course would be determined was irrelevant information for the purpose of the study, I did not include it as part of my data set (Munhall, 2001).

Participation was voluntary and interviews were conducted in private locations at a mutually convenient time outside of working hours. Although I had intended to conduct the interviews outside of the hospital so participants would feel their participation would remain anonymous, all but one face-to-face interview occurred in the hospital library or board room. These locations were chosen by the participants themselves and so I

concluded they were comfortable with colleagues being potentially aware of their participation in this study. All videoconference interviews occurred in the room designated for telehealth conferences within the hospital. One face-to-face interview occurred in a local post-secondary facility.

Anonymity

The participants' anonymity has been and continues to be protected by keeping consent forms and demographic information in a locked filing cabinet separate from the audiotapes and transcriptions. Code numbers were used on the transcripts and all potentially identifying information such as names of people, employers, medical conditions, events, and places have been disguised. To make it easier to read in the "results" section of this paper, pseudonyms were used rather than code numbers. To describe the rural hospital context, using the demographic details provided by the participants, the "Dog River" Community Hospital was created so the description of this fictional hospital could be of any rural hospital.

I also explained to the participants that excerpts of small portions of their interview(s) and my observations would be used in writing the findings and in future publications although their personal information and identity would be kept confidential. Furthermore, unimportant details would be changed or eliminated when illustrating a theme (Lipson, 1994). Lastly, I explained that if data were used for secondary analysis after this study was completed, the subsequent study would undergo another ethics review to ensure the proper use of the data.

Note: The following pages are charts representing the analysis of the data.

Domain	*Category*	*Taxonomy*	*Taxonomic analysis*	*Paradigm*
Life in "Dog River"	physical distance (from nearest urban center) population attraction to the area industry resources health care services isolation outsiders are outsiders	population growth	housing is going crazy, economic prosperity, growth has both +/- consequences, people are accepting (of newcomers), increase flow of transients, increase in drug problems	**Town Growth**
		health care services	types of health care services, have drs leaving, we run an outpatient clinic after office hours, town growth results in greater usage of local health care services & facilities, long-term care crisis, regionalization has an impact on how services are offered in rural hospitals	*potential meaning associated with town growth: uncertainty*
		Isolation physical	plenty of ways to get out of town being so far away can commute, easy access, things to do more limited in winter, high cost of leaving location, "we re so central", in the hospital don't have as many services, anything really acute we send out, don t see many new & exciting things (equip., different ways of doing things)	**Isolation**
		Isolation emotional	nobody s coming up here (especially in winter), shift work, can t find people of the same age & who have the same interests, very cliquey, don't share a past don t have female sports, coping with emotional isolation do other things join a group meet people through work head out for a few days (short holidays) I know I'm leaving, here for a short while	*potential meaning associated with isolation: depends on ability to adjust*
		outsiders are outsiders	considered a local if you have "roots here" i e family, a shared past had children while living in community share same friends & interests, multi-generational, don't move far away know everybody residents are involved in every aspect of the town outsiders aren't necessarily newcomers being a local means you have a voice to become a local takes a long time need to learn to be one of them need to be involved in certain activities (having children helps becoming involved) need to work your way in , attitude if you can get through the winter	**Outsiders**
				potential meaning associated with outsiders: to become a local takes time & requires certain conditions be met
				Thoughts regarding this domain: Towns are growing. Growth produces uncertainty for locals since newcomers have not met the conditions to be considered local (time and characteristics). Hence, newcomers are likely to feel emotional isolation. Coping with emotional isolation is dependent on the newcomers ability to adapt to the rural life style. To feel like a local means to feel a sense of belonging

Town Growth

Contrast Set	Dimensions: housing	local economy	lifestyle	permanent resident
transients	more houses	bring business	close to city without being in the city	not necessarily
newcomer	more houses	bring business	close to city without being in the city	not necessarily but feel some need to belong
locals	sell houses > $	have more business (increase in resources)	change in life style (impact on farm land)	multi-generational

Isolation

Contrast Set	Dimensions: able to leave	distance	activities	connect with others	healthcare
physical	plenty of ways to get out, commute costs lots of $	far away, central	depends on season	easy access	limited services & resources (equipment)
emotional	for short holidays, here for short while	nobody comes up	can't find people with same interests, do other things	nobody comes up, cliquey, shift work, don't share past, can't find people same age	meet people at work

Outsiders

Contrast Set	Dimensions: roots	high visibility	involvement in town activities	adhere to expected norms, values, behaviors	have a voice
transient	no	no	generally no	no	no
outsiders	deep	know everybody	no (keep to themselves)	are people who have odd quirks	no
newcomers	superficial	don't know everybody	varies	need to learn these	no
locals	deep, multi-generational	know everybody	yes	yes	yes

Domain	Category	Taxonomy	Taxonomic analysis	Paradigm
"Dog River" Community Hospital: Grey's Anatomy it's not!	demographic characteristics	number of beds types of services offered within the hospital ancillary & support staff medical coverage nurse staffing & associated responsibilities	a typical shift an atypical shift and you run for the rest of the day	**A Shift in "Dog River" Community Hospital** Dimensions Contrast Sets: workload; routine; delivery mode of patient care typical shift: predictable; maintain "basic routine"; team nursing atypical shift: unpredictable; disrupted "throws everything off"; one-on-one potential meaning associated with a shift in DRCH: need to be able to adjust to unexpected situations
	social characteristics	pace in the hospital is different than in urban facilities changing utilization patterns of hospital beds		**What Being a Nurse in "Dog River" Community Hospital is Like** Dimensions
	the hospital team	home grown better than average nurse team player need to hold certain professional values professional development of a rural nurse nursing practice in a rural hospital	We're it We work as a team We're family Community ties	

Contrast Set	medical support	rely on nurses knowledge	work outside regular nrsg duties	home grown	better than average nurse	team player
we're it	limited, need to know who to call & when	especially on nights	especially on nights	no	yes	yes
we work as a team	rely on each other	know who has specialized knowledge	don't have people at your finger tips	no	yes	yes
we're family	includes all staff	have personal knowledge of each other		no, but there are some advantages	no	yes
we have community ties	drs also have community ties	nurses know their patients		no, but there are some advantages	no	no

potential meaning associated with what being a nurse in DRCH: being home grown is not essential however nurses need all kinds of knowledge and need to be able to work with others because the team is "tight knit"

Thoughts about this domain: The work pace in a small rural town hospital is generally slower than in large urban hospitals. Nurses need to be adapatable. Although being home grown is not essential, nurses must be able to work as a team player and need a wide variety of knowledge (professional and personal) and skill

Domain	*Category*	*Taxonomy*	*Taxonomic Analysis*	*Paradigm*
"Dog River" Community Hospital: a great placement'		meaning of preceptoring	joint effort/partnership expectations vary emotional investment requires preparation opportunity to teach builds confidence builds bridges btw generations	
		motivation to preceptor	revitalizes keeps you current shape the next generation become a learner emotionally & cognitively tiring	
	'I'm getting a student'	motivation for other staff to support the preceptorship	another set of hands shape the next generation potential employee opportunity to expose students to rural hospital nursing ensure a good learning experience administration is the connection btw the facility & educational institution	
		goal of preceptorship required preceptor qualities	depends on the student/preceptor relationship need to learn to deal with the 'ups & downs' need to deal with shift work required preparation for clinical need to learn to make patients comfortable with your care as a student may have conflicting views of what nursing is about with your preceptor	
	benefits of the preceptorship experience	generally can become a mentorship rural preceptorship challenges of preceptorship	things are done differently understanding the dynamics of the hospital required preparation for clinical learning a new environment securing the learning experience commuting financial burden	
		challenges of a rural hospital	lacks organization limited opportunities to learn specialized psychomotor skills/resources potential to be overwhelming multiple preceptors small number of staff	
		preceptorship why rural hospital are better for learning	advantages of being home grown have previous rural hospital experience interest in rural nursing willing to be immersed in rural hospital nursing practice	
"Dog River" Community Hospital: a great placement'	student characteristics	interpersonal & critical thinking able to guard the learner role be home grown	learn theory of preceptorship do a personal inventory learn about the community learn about the hospital know your expectations of the preceptor things will be different be prepared to look things up 'there's going to be ambiguity & diversity every shift' be prepared to be known be prepared to know your patients be prepared to 'go that extra mile' don't be scared - it's hard to prepare	

What Preceptorship in "Dog River" Community Hospital Means

Contrast Set	Dimensions: joint effort partnership	expectations	preparation	teaching & learning opportunity	build confidence	builds bridges	faculty involvement
I'm getting a student	yes	varies with level of student	personal inventory	yes	yes	btw generations	limited
I'm going to a rural hospital	yes	of preceptor	requires emotional, psychological, cognitive psychomotor	yes	yes	theory & practice, std role & grad role, generations to mentorship	admin the course

potential meaning: student preceptor relationship is central to the experience

Domain	*Category*	*Taxonomy*	*Taxonomy Analysis*	*Paradigm*
I belong in "Dog River"		the work of being preceptored	building a bridge btw the student & staff building a bridge btw theory & practice building a bridge to transition from being a student to being a graduate nurse	
		becoming part of the team "what it takes"	isn't based only on critical thinking or professional ability characteristics needed strategies to become part of the team	
	the student experience of a rural hospital	knowing you're part of the team	it's a matter of perception feel valued known as a person knows as a professional feel respected are trusted possess implicit knowledge of how the team works staff don't want you to leave are an employee now being unable to become part of the team	
		faculty involvement in the experience, making the experience better	administration of the course supporting the student supporting the preceptor	
	the preceptor experience of having a student	the work of preceptoring	build bridge between theory & practice build bridge between staff & student build bridge between student & graduate role	

Becoming Part of the Team

Contrast Set	Dimensions: bridge btw student & staff	bridge theory & practice	bridge student & grad role	organizational satisfaction	knowledge of how the team works
part of the team	yes	yes	yes	feels valued, respected, known as a person & professional, affirmed (staff don't want you to leave)	yes
unable to be part of the team	limited, basis is friendship	yes, but opportunities are limited	no, student feels confused, angry	feels not trusted	somewhat, has difficulty identifying relationships

potential meaning: sense of belonging is essential for the preceptorship to be successful

CHAPTER FOUR
RESULTS

In this research I wanted to explore the experience of preceptors and students in a rural hospital setting. Specifically I wanted to explore the experiences and perceptions of nursing students and nurse preceptors during a rural hospital preceptorship. By considering my own experience of working as a registered nurse in two rural hospitals and teaching nursing students in the rural setting, speaking with nurse colleagues and rural residents many of whom have accessed hospital services, and reviewing the literature, I knew the rural hospital setting was unique and complex. I also knew that for a variety of reasons this setting could be challenging for students who undertake a preceptorship where one of the goals is for them to transition from the student to the graduate role. To discover what actually happens in this setting, I had to approach this investigation in an open manner while being aware of my own biases and preconceptions of the setting and experience.

In this chapter I will describe four interrelated domains that represent the experience of being a student and preceptor in a rural hospital: "Life in "Dog River" represents what living in a small rural town might be like; "Dog River" Community Hospital: Grey's Anatomy it's not!" represents what working in a small rural hospital might be like; "Dog River" Community Hospital: A great placement!" represents the meaning preceptorship has for the participants of this study; and "I Belong in "Dog River" describes the experience of students and preceptors during the preceptorship.

To end the chapter, I explain how the cultural theme "a sense of belonging" connects the domains. According to Maslow (1970), belonging is a universal characteristic of human beings and is a basic human need. It occurs when there are

pleasant or neutral interactions that occur within an ongoing relationship where there is mutual caring and concern (Baumeister & Muraven, 2000). A sense of belonging may also offer a shared sense of socially constructed meaning that provides a sense of security or relatedness. Generally then, people strive for a connection with others in order to be accepted by others since being or not being connected to others has cognitive, affective, and behavioral consequences (Andersen, Chen, & Carter, 2000). With this in mind, using the participants own words, the experience of being a student and preceptor during a rural hospital preceptorship is now presented.

Note: because there are a number of participants in this study, so that you might know each participant and be able to frame their experience a bit better according to their status as either being a nursing student or nurse preceptor, the table below is provided for your reference.

Table 1: Description of Participants and Status

Name of participant	Status
Lena	Current preceptor
Donna	Current preceptor
Laurie	Current preceptor
Angie	Current preceptor
Daniel	Former preceptor/living in rural community
Devon	Former preceptor/living in rural community
Merissa	Former preceptor/living in rural community
Elanor	Former student/current rural hospital nurse
Candace	Former student/current rural hospital nurse
Linda	Former student/current rural hospital nurse
Olive	Former student/current rural hospital nurse

Cassie	Current student/experience living in rural towns
Samantha	Current student/experience living in rural towns
Katie	Current student/experience living in rural towns
Patricia	Current student/experience living in rural towns
Janie	Current student/experience living in rural towns
Sandie	Current student
Bob	Current student/experience working in rural hospitals

Life in "Dog River"

In *"Corner Gas,"* the television program, the theme song proclaims "there's not a lot going on" in "Dog River". Although it does not accurately represent the participants' experiences of rural life in this study, it certainly does bring to the forefront what many of us believe living in rural Canada is like. We believe small towns are slowly fading from our country's vista as people migrate to cities (Mwansa & Bollman, 2005). Contrary to this perception, all of the participants in this study, who were living within the rural communities in which the preceptorship experience occurred, indicated their town was growing. In fact *Lena* explained

> *because of the oil and stuff, housing is going crazy here! There are no lots. When they do get lots, they have to do a draw. Not long ago there were about 15 lots and about 40 people who wanted them. So they had to do a draw: like a lottery draw kind of thing. You had first dibs when your name came up but you had to have your down payment by that evening. Town lots are kind of scarce now. Lots of building going on.*

Indeed one-third of all rural communities in Canada experienced continuous demographic growth between 1981-2001, with larger rural communities experiencing growth at a greater rate than smaller communities (Mwansa & Bollman, 2005).

So what does this growth mean to rural town residents? According to the participants in this study, demographic growth meant having more resources. For example, many large box stores and fast food restaurants were being built. For some participants, this type of growth was welcomed since it meant they did not have to leave town to go to the city to purchase items. However, some participants noticed that the arrival of large box stores also negatively impacted the downtown core where traditionally businesses and consumers converged. *"Those box stores out there have kind of taken away from the downtown. I've noticed downtown is dead!" (Elanor).* Although demographic growth has resulted in economic prosperity for some town residents, because of a greater demand for a variety of services, other residents who depend on the "mom and pop" type of business for their livelihood may not have faired as well.

The economic boom in Alberta has also created an influx in the transient population within these small towns particularly in northern Alberta (Aylward, 2007). Town residents suspect that transients will not necessarily become permanent residents. Their concern is that the fabric that makes up the nature of small rural towns will become unraveled, leaving them feeling uncertain of what the change might bring.

> *Some of the [residents]say, "Sure, let the town grow. It's exciting, there's lots of things happening, there [are] lots of people here, we can be independent of the city." Other people say, "No, let's keep our community the way it is, keep it small and friendly" and they're afraid that if we let more people in and more industry in that we won't have that small town atmosphere (Donna).*

For the participants in this study, transients were not necessarily people who lived in the community for merely a few months. The term transient included those people who had lived in the community for some time, but who would also leave the community

within a certain number of years. These people were usually professionals whose career necessitated frequent moves. Some participants who had lived upwards of 15 to 20 years within the community, although not considered transients, still felt like newcomers, sometimes outsiders, and most certainly not locals. *Daniel* felt to become a local might take *"25 years or more. It's taken a long time to get into anybody's circle. I've been here 16 years and I'm no where near being a local. Outsiders are outsiders."* This distinction warrants further explanation so that we can understand what living in a small rural community like "Dog River" might be like.

The character, Lacie, in the television show *"Corner Gas,"* is a newcomer (Sutermaster, 1998) to "Dog River." Although she has inherited her aunt's coffee shop, she does not know many people, is unfamiliar with the history of the area and its residents, and does not seem to have any family in the community: she is a stranger. As a newcomer, Lacie has to learn how to be a local. To do this, she frequently tries to involve herself in town activities. Like Lacie, *Daniel* and *Cassie* have found that to become a local "*you have to be involved in the local political scene, maybe the local business scene. Being in the hockey circle when the kids were growing up isn't enough. Certainly you're part of the group then but you're still not a local"* so *"you kind of have to put yourself out there. That's kind of how it works."* Indeed, community members who are considered locals seem to be involved in *"just about every aspect of the town" (Cassie)* and so have a deep abiding sense of belonging to their community (Turcotte, 2005). *"[They] have a genuine concern and [they] work together" (Cassie).*

For the character Lacie, and some of the participants in this study, putting oneself out there is not quite enough to become a local, thereby making integration into the

community difficult for them (Sutermaster, 1998). In fact, age, long-time residency, and land ownership where "*it's multigenerational farming" (Devon)* are some other characteristics of a local or "old-timer" (Boland & Lee, 2006). They *"have roots" (Daniel)* and come from families that have long been established in the community. Like most rural residents (Turcotte, 2005) "*where everybody knows everybody," (Samantha)* according to the participants in this study, locals are multigenerational and share a past with other community members.

Newcomers, however, "*still meet people in the street that [they've] never seen before" (Daniel)* and so do not share a past with local residents. Along with not knowing everyone, newcomers do not possess knowledge of the rules and expected behaviors of how locals behave. Indeed *Daniel* suggests that learning the rules and behaviors of how locals behave is sometimes very difficult and might result in being unsuccessful in becoming a local. *"We have very few friends that come over for coffee or dinner or a barbeque. Those things don't work here" (Daniel).*

Unlike newcomers who are learning to be a local, that is being "*one of them" (Katie),* transients do not have roots and may not have a sense of belonging to the community. Outsiders (Bailey, 1998) may have roots but they do not adhere to behaviors that are considered acceptable as a member of that community.

> *As for the outsider, these are people with odd quirks that are a little different. They're more isolated from the community, they keep themselves out. I've seen some people around here that live in shacks with no water, no electricity. Some locals consider those people as outsiders. Outsiders have weird behaviors or have a family history of weird behaviors (Katie).*

As a newcomer, and perhaps even as a transient or outsider, we can expect the feeling of isolation to be significant because of the potential difficulty these people might

encounter in integrating into the small town (Sutermaster, 1998). It is easy to imagine that the character Lacie, in *"Corner Gas,"* felt lonely and isolated after relocating to "Dog River", hundreds of miles away from Toronto. Participants in this study spoke of both geographical and emotional isolation. For *Patricia*, the sense of being geographically isolated was enhanced by not only the physical distance from an urban center but as well by the season. Long, dark, cold Canadian northern winters made leaving the community extremely difficult and seemed to reinforce for her that she was living a long distance from the city. While all the other participants recognized geographical location might have an impact on feeling isolated, for them, physical distance from an urban center did not appear to impact their feelings of isolation (Carrick, 1998). They explained that the ease with which they were able to leave the rural community as well as their physical location within the province helped reduce the feeling of being physically isolated.

When *Patricia* describes her experience of living in a northern rural community where *"nobody comes up here,"* she seems to be indicating that isolation involves being set apart from others: a state of being that is undesirable (Carrick, 1998). Other than living a long distance from the city, even if only temporarily, being set apart for some study participants was experienced because of an inequity in power (Carrick, 1998) that resulted from being a newcomer or transient within the community. This type of isolation was experienced when decisions needed to be made that affected the town in general. *Daniel* suggests that because locals *"have a local base, [they are] more apt to be heard."* This comment suggests newcomers have little or no voice in small rural communities and so experience isolation.

Because many of the participants had not been born or raised in the rural community in which the preceptorship was undertaken, they did not share a past with other community members and so did not *"have the same circle of friends because the circle of friends here extends generation to generation" (Daniel)*. They frequently told me they were unable to find people of the same age and who shared similar interests.

> *I find that the people here that are our age are very cliquey because they've all been here since kindergarten and have grown up together and all gotten married together and have all started their families together and they don't have any room for anybody else. Yeah, definitely I'm an outsider. So in that respect I find this community very isolating. I find it really hard to find friends, to break into new groups of people because they've already got their groups made (Devon).*

Not only was being a newcomer a disadvantage in being able to find friends, *Candace* felt that unless friends could be found through work, emotional isolation was a very real possibility. Affiliation with a group was perceived as far more difficult. For example:

> *… they have an oil field wives club and you can't be associated with it unless you're married to someone who works in the oil field. And there [are] the mill wives. I think it would be very hard if you came here and weren't associated with something. I don't know how you would get to know people (Candace).*

To cope with emotional isolation the character Lacie in *"Corner Gas,"* participates in a variety of activities. She attends Bingo, goes to the local hotel whenever Brent, Hank, Wanda, Emma or Oscar are there and even helps coach the local hockey team. Participants in this study also joined groups and participated in various activities in order to relieve their emotional isolation. However, the participants in this study also worked shift work. According to *Janie*

> *... if you're doing shift work, it's hard to get that other social aspect where you can have friends because you're not in any regular activities. You can't go to ladies night for golf because you're working three Thursdays in a row, and so I think that places a challenge.*

Although Turcotte (2005) has reported there is no difference between rural and urban residents in social isolation from family or friends, there is perhaps a difference in the power structure in the relationships between rural and urban residents. While urban residents are less likely to know their neighbors, rural residents most likely know all or most of their neighbors. A newcomer or transient resident is not part of this complex web of relationships. There is, therefore, a condition of implicit power that reinforces the sense of isolation. As *Daniel* poignantly states *"newcomers are newcomers"* they exist outside the social circle of locals. In this study, the power which reinforced the sense of emotional isolation for newcomers and transients was the knowledge of "how to be a local." Indeed *"if you don't fall into the expectations of the locals, it becomes very difficult to make your way" (Candace). You're always considered newer and an outsider even though you end up being here for 40 years. In towns like these you're always an outsider until you've been here for generations (Cassie).*

"Dog River" Community Hospital: Grey's Anatomy it's not!

Although in the television program *"Corner Gas"* there is no hospital, using hospital demographics obtained from the participants in this study and site visits, let me construct for you what a typical rural hospital might be like. I have called this fictional hospital the "Dog River" Community Hospital.

"Dog River" Community Hospital is located at the end of the street one block south of Main Street. Built in the early 1980s, it is a low single story brick building. Extending on either side of the main entrance are two "wings." One wing has a bright

neon *"Emergency"* sign hanging above large garage doors. It beckons to those who are in need of care regardless of the time of day. The closest tertiary health care facility is 150 kilometers away. On a clear summer day with little traffic on the two lane highway, an ambulance can transport a patient from the rural hospital to an urban facility within 60 minutes. Entering through the main doors, the unmistakable odor of cleanliness unique to hospitals assails your sense of smell. You see the reception area to your right. Behind this area is the medical records section. To your left is the outpatient waiting room. Moving forward a few meters is the nursing station. The nursing station gives you the impression of a sentry standing guard over the remainder of the hospital. It is the hub of activity: the command post. To the right of the nursing station are three hallways. Two lead to patient rooms where 20 patients sleep. The third hallway leads to the board room, staff cafeteria, kitchen, and administrative offices. To the left of the nursing station is the five stretcher emergency department. Across the hallway from the emergency department are the diagnostic imaging and laboratory departments. For the moment all is quiet. Two weary nurses are sitting at the nursing station desk finishing up their tasks before they can go home. The third nurse is in one of the patient rooms attending to a patient's needs.

Although the conversation that follows between the nurses Sheila, Penny and Ellen is fictitious, it does display many of the characteristics of rural hospital nursing practice I found in my study and ties the four categories of the domain "Dog River" Community Hospital: Grey's Anatomy it's not!"

Sheila: "Morning, Penny! Morning, Ellen! How was your night?"

Penny: "It was crazy! We ran all night!"

Sheila: "I heard the ambulance. What happened?"

Penny: "Old Joe came in again. They found him in the barn. He was checking the cows and apparently he just dropped. This time I don't think he'll make it."

Sheila: "How's Esther taking it?"

Penny: "As well as can be expected. Bob and Sharon are here with her. John and Alice's boy came in. He was driving his skidoo near Harry's place and ran into a barbed wire fence in the ravine. We had to call Mary-Jane in for x-rays. It looks like he fractured some ribs and probably ended up with a pneumothorax so we sent him out. Hope he's doing o.k. I don't know what Alice would do if she lost Derek. That family has had enough tragedy! We just got settled and then Joyce came in. She had it pretty rough but managed to deliver around three. You should have seen Ben: he was over the moon! You should see the baby: he's so cute and looks just like his grand-dad! Anyway we had to call Ian to come in. After we had called him for the third time he decided to sleep in the doctor's lounge but he wasn't too happy having to spend the night here!"

Sheila: "Sounds like you had one of those nights."

Ellen: "Yeah. To add to the chaos Oscar was on the bell all night! You know how he can be! Before I forget I haven't had time to wash the dishes from the delivery. They're still in the dirty utility room. Sorry about that. I'll try to get them done before report is out. Man, I'm happy to be going home! By the way I'll pick you up around seven to head over to the rink. The bonspiel starts at eight."

Sheila: "Sounds good. Don't forget to pick Wanda up."

Ellen: "I heard Lacie is trying her hand at curling. That should be good for a laugh!"

Before we can turn our attention to the categories which make up the domain of "Dog River" Community Hospital: Grey's Anatomy it's not!", understanding who the

rural nurses participating are in this study will help set the context. Similar to the findings of a national survey, the number of years as a registered nurse seemed to display a dichotomy of experience both as a registered nurse and as a registered nurse servicing rural communities (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004). Of the six registered nurses participating in this study, three nurses possessed extensive experience of 17 or more years while the three other nurses were relatively new to the nursing profession having three to five years of experience. Of the three nurses new to the nursing profession, two were born and raised in the community in which they worked. All of the nurse participants had a minimum of three years experience working in a rural hospital, while the more experienced nurses had over 17 years of experience

For the nurses in this study, the number of practice years was important. Unlike the nurses in Scharff's study (2006) who indicated there was no clear demarcation for when a nurse makes the transition from new to old-timer, or how one arrives at a level of acceptance, according to *Daniel,* rural hospital nurses only *"start to become good at five years and are good at 10 years."* From this comment I discerned that a nurse's level of proficiency takes time to develop because of the complex and ambiguous nature of rural hospital practice. The transition from being new to being considered an oldtimer occurs as a nurse becomes more proficient.

Now that we have an understanding of who rural hospital nurses are, characteristics of their practice can be described. To describe the nature of their practice, the nurses in this study used words like "we're it," "we work as a team," "we're family," and "we have ties to the community."

"We're it"

The complexity and ambiguity of rural hospital practice is embedded in the comment *"we're it."* Like the nurses in MacLeod's (1999) and Scharff's study (2006) and like Penny and Ellen in the "Dog River" Community Hospital, nurses in this study described situations where they moved between providing nursing care in life threatening situations, to providing care to a laboring woman and her family, to meeting the health care needs of medical patients within a span of a shift or even within a few hours. Because of the wide variety of nursing care areas in which they could expect to provide care, many of the nurses in this study felt expertise in two nursing practice areas was ideal since they were expected to provide care to the same standard established by certified nursing areas (Rosenthal, 2006). However, because of the limited number of expert staff and at times their own limited experience in some areas of nursing practice, in some of situations the nurses in this study were required to make decisions based on knowledge and skills infrequently used. As a result, to ensure positive patient outcomes, these nurses felt they needed to *"have a broad knowledge base" (Laurie), "have good assessment skills" (Elanor), "be able to prioritize care" (Daniel),* and *"be adaptable ... be a jack of all trades" (Merissa).*

Furthermore, the reality of rural hospital nursing practice is that immediate medical and ancillary support is not always available. At times the "right kind" of medical support might only be available through telephone consultation. Often times the unpredictability of having readily available medical support leaves rural hospital nurses feeling alone in being responsible for patient outcomes (Scharff, 2006), thereby emphasizing for them the notion of *"we're it."* Indeed, we get the feeling that for *Katie* being alone and being responsible for patient outcomes is part and parcel of the nature of

rural hospital nursing practice. *"Usually the nurse orders everything...any lab work and x-rays if we think it's needed. Then we'll call the doctor. Usually doctors don't want us to call them until everything like that is figured out."* To cope with this responsibility these nurses expressed that they needed to possess a great deal of confidence in their practice as well as in their *"ability to learn something new quickly" (Daniel)* in order to make effective decisions.

Although all of the nurses in this study were reluctant to admit they practiced medicine, practicing in a rural hospital with limited medical and ancillary support frequently required that they practice to the limit of their nursing scope of practice as defined by their professional association. Because all but one hospital in this study did not have a physician in-house 24 hours a day, by necessity physicians had to rely on the nurses' knowledge and skills in providing appropriate medical care until they could get to the hospital. However, the type and extent of care provided in that grey area of *"we're it"* was mitigated by how well the nurses knew the doctor and how well the doctor knew them. Comments such as *"normally it's simple things and you know the doctor so you know what you can get a cover order for"(Linda)* seemed to indicate knowing each other as professionals is a significant factor in the provision of nursing care in a rural hospital.

Although not one of the attributes of the concept *"we're it"* (MacLeod, 1999), the nurses in this study recounted unlimited instances where they needed to take on the responsibilities and duties normally carried out by other staff members and professionals. As *Angie* eloquently puts it:

> *... you have more roles and responsibilities than a nurse in a bigger hospital does because in the middle of the night you are the nutritionist, you are the social worker, you are the First Nations Health liaison, sometimes*

you are even the lab. You have to get a blood draw. You are the R.T. person. I think you practice a little bit of a broader scope.

For these nurses then the notion of *"we're it"* permeated all aspects of their nursing practice, making it a distinctive characteristic of rural hospital nursing practice.

"We work as a team"

Although nurses in Scharff's study (2006) felt the independent nature of their practice resulted in feeling alone, the nurses in this study were adamant that they felt a strong sense of "we're a team" and that *"there [was] always somebody to call to come and help" (Merissa).* These nurses quickly recognized those among them: the ace and pinch hitters (Scharff, 2006) who possessed advanced knowledge, skill, and experience. As a consequence, they did not express any hesitancy in asking that particular individual for assistance or guidance because *"she [was] the best resource" (Samantha).* To be sure, in moments of crisis, the nurses in this study paint a picture of a group of individuals who know each other so well that they provide patient care seamlessly much like ballroom dancers faultlessly executing the complex choreography of a Rumba or Salsa (Scharff, 2006). *"We are such an efficient team here that if somebody comes in with chest pain we all know that somebody's got a job, there's very little talking because everybody has taken on a role" (Mary, focus group).*

Although professional development opportunities were available to the nurses participating in this study, they also identified a number of obstacles in securing and being able to attend conferences and in being able to take courses. Sharing with each other what they had learned became an important strategy in being able to maintain current knowledge and skill (Scharff, 2006).

Although working as a team was without doubt essential in moments of crisis or when a situation occurred which disrupted the predictable routine of the shift, it was equally important for the nurses in this study to work as a team during a typical shift. Providing that *"all the nurses know what's going on everywhere all the time, [and that they are] aware of the big picture" (Daniel),* nursing care could be efficiently and competently provided, yielding patient satisfaction and positive outcomes, as well as staff satisfaction with the work environment.

When discussing the concept of "we're a team" with the participants, it became clear that nurses needed certain attributes to be part of the team. These included possessing knowledge and skills of an expert nurse as well as the ability to communicate clearly and effectively with colleagues, other staff members, and patients; being friendly; possessing the ability to manage multiple demands in order to *"keep on top of everything"(Daniel)* ; and knowledge of how the team works in nonemergent situations. They made comments such as *"I think people who were more expert and outgoing were more easily accepted" (Samantha),* and

> *I was told by a LPN on a night shift that even though I was in outpatients, in the morning when they wash people up I had better get my butt over there to help out or I won't get any help out in outpatients. I could be on my own" (Elanor).*

Apart from possessing certain characteristics as an individual, team members also had to know how to make the team work. In the scenario that started this category, Penny, the registered nurse, exclaims that Ian, the physician was not happy having to spend the whole night at the hospital. Although most of the nurses in this study report that the nurses in their hospital *"have a very positive relationship with [the physicians]" (Sandie),* comments such as, *"all the doctors have their own little ways they like things*

and their own little quirks" (Elanor) indicate that rural hospital nurses must continually refine their understanding of physicians preferences in order to be trusted (MacLeod, 1999) and to make the team work effectively; however, in situations where there were inconsistencies in nursing care or changes in protocol that were deemed unnecessary by the physicians, the relationship between the nurses and physicians became strained. Unfortunately like the nurses in MacLeod and Zimmer's study (2005), nurses in this study reported that they sometimes felt powerless to bring about change or sustain change although they felt confident change was warranted and would result in better patient outcomes.

> *The doctors throw their weight around and they try to get things changed to how they think the hospital should be run. For example, we got to custom make our own charting system and we think that it's fabulous! It cuts down on our time charting, it's precise, accurate charting. Well two of the physicians don't agree with it and basically refuse to look at our charting unless it's put in narrative notes. They've gone so far as to taking it to the director of nursing and they've tried to get all our charting changed back to narrative. I think that the rural setting has a lot to with how the relationship is because we are a bit more isolated. The way that the nurse and physician relationship has been for the last 20 years is all that these people have ever known. The doctor tells them this is what we're doing and everybody is o.k. that's what we're doing because he said so. But I think that when it comes to nursing issues, it should be nurses that deal with it and I think that charting is a nursing issue. I don't think it's a physician issue. Other things too that they have tried to meddle with are nursing issues but they keep trying to put their say in but it's not their say. They're not the ones that are here 24 hours a day doing the charting, we are. So I found it very hard to deal with when it's almost like you against them (Devon).*

While having a good rapport with physicians was necessary to work as a team, because of the limited number of nursing staff, it was equally important for nurses in this study to have good rapport amongst themselves. Although it is likely that nurses in any setting develop close relationships and as a consequence have good rapport, rural hospital nurses share not only knowledge of themselves as professional nurses because they

"consult with each other a lot" (Sandie), "trust each other" (Laurie), and value the contribution to the provision of care made by their colleagues, they also know each other personally. The added dimension of knowing each other personally generally had a positive influence on their practice (Scharff, 2006) because they *"know how to talk to each other" (Donna)* and *"you understand them better" (Samantha).* As a result *"the team is very cohesive [and] it makes for a place of satisfaction to come to work because they are coming to work with their friends" (Bob).*

Often times viewed as a positive source of support because they care for each other (Gater, 2003) and have high regard for one another (Scharff, 2006), knowing each other personally also required nurses who experienced conflict to *"get over anything personal and work together to help this person" (Elanor).* Confronting and managing conflict therefore, was an essential component in supporting the group's cohesiveness (Scharff, 2006), as well as a strategy for maintaining effective team functioning. Therefore, the attributes of a well-functioning team that included role overlap, satisfaction with interpersonal communication, and having a shared purpose (Dreachslin, Hunt, & Sprainer, 1999) were dependent on each nurse adhering to the expected behaviors associated with being a team member.

"We're family"

Some of the nurses in this study had been born and raised in the town in which the preceptorship was being undertaken and now were working at the local hospital. While other nurses had not been born or raised in the community, they had been working at the local hospital for as long as they had been living in the community which in all but one case was a considerable amount of time. Rural hospital nurses therefore, tend to know

each other beyond the general familiarity nurses in urban settings are accustomed to. In rural hospitals, nurses know each others' spouses and children, each others' family, social and business connections, and each others' interests, likes, and dislikes. They have knowledge of situations such as marital breakdown or financial concerns that in an urban setting might be considered in the realm of private knowledge but in a rural setting are considered "public" knowledge. *"Everybody knows what shifts you're on, what's going on in your personal life" (Linda)* and sometimes *"if somebody is having lots of personal problems, you can get really involved in that you're [helping her out] at work asking how things are going" (Lena).*

Although some nurses *"limit their social ties" (Daniel)* with their colleagues, the majority of nurses spend time with each other outside of scheduled work time because *"people want to know each other better" (Merissa).* It was not uncommon to hear them describe their colleagues as *"sisters" (Candace)* blurring the boundaries between work and nonwork relations (Pettinger, 2005). While most of the time the blurring of professional/personal boundaries had a positive effect on the work environment, sometimes personal conflicts had a spill-over effect into the work place that could *"bring the whole team down" (Lena).* As noted above however, because it was essential for the team to work effectively as a group to ensure positive patient outcomes, nurses self-monitored (Pettinger, 2005) the impact the conflict could have on the work environment and on patients. They actively engaged in professional behaviors with the colleague with whom they had a disagreement so that the team could continue on with their work. *"Professionalism is very important here. I mean you might have to go around the corner and count to 10 but you still have to work with these people!" (Mary, focus group).*

In describing themselves as family, these nurses understood the meaning of family at a sociological or psychological level (Goode, 1964). They shared a commitment of maintaining their relationship with each other and of creating a sense of being at ease with each other: two attributes that are generally ascribed to families (Henley Walters, 1982). This was particularly noticeable in times of personal crisis. Although nurses in urban centers might offer to help one another (Turcotte, 2005), because these rural hospital nurses cared deeply about each other, they did not hesitate to offer emotional support as well as offer their help in countless other ways especially during personally difficult times. For example *"when the charge nurse's mother passed away, everybody went and helped her out with the funeral and made sure she had the days off. We're a close knit unit here; everybody knows each other" (Katie).* The notion of belonging (Winter-Collins & McDaniel, 2000), therefore, was embedded in the description *"we're family" (Mary, focus group)* making rural hospital nursing unique.

"We have ties to the community"

It was really clear that the participants in my study knew their patients personally and medically. Long regarded as a hallmark of rural nursing (Bigbee, 1993), nurses working in any small town hospital know not only their patients' medical history, but, their familial and religious associations, where they live, what type of work they do, activities they are involved in, and how others in the community view them. Knowing their patients as they do, sharing of knowledge is based on the assumption that what might be considered "private" knowledge of the patient in other settings is "public" knowledge in rural hospitals. *Olive* notes that

> *nurses who've worked here for awhile, when somebody comes in, they can give you the background on them. For example, they might say: 'This person has done*

> *this and done that so wear gloves.' Often whoever came in to visit, they knew something about them.*

While in an urban setting this type of information might be considered inconsequential, uninformative, and perhaps even irrelevant, in a rural setting it is considered crucial in the provision of nursing care. *Candace's* comment clearly demonstrates how knowing their patients as they do, their knowledge has a direct positive impact in the provision of nursing care.

> *If [a patient] comes in and is disoriented, you know what meds the patient is on already or you know which pharmacy he's at so it just eliminates a lot more of the confusion and just makes the process a lot faster (Candace).*

Knowing their patients as they do also potentially increases the depth of interaction (Scharff, 2006) because not only is more information shared, *"being a local and being identified as a local, you can sometimes get more information out of patients because they know you" (Devon),* but as well it is understood and considered relevant within the context of the patients' experiences. For example, *Devon* explains how the nurse's knowledge of the patient and their family and friends has the potential to bring more understanding of the patient's experience of health.

> *A patient comes in and says "I was at Johnny's place when my chest pain started and Myrtle was there and Myrtle called 911" and you're this nurse that knows everyone he's talking about. I think the nurse is at an advantage because she can picture the whole scene in her head as to how things kind of transpired. There have been people who have come in and the nurses are more aware of their history and what type of relationships these people are coming from. They know Mr. and Mrs. Smith have had an abusive marriage for the last 25 years. They're not surprised when Mrs. Smith comes in with alcoholism where as me, I've never laid eyes on these people before and I'm oh she's like an alcoholic, let's get her into AA and let's do this and let's do that and they're like "no, you don't understand, this has been like this for the last 25 years because her husband is abusive."*

Furthermore, for the rural hospital nurses in this study, personally knowing their patients increased their sense of personal accountability toward their patients and the community (Rosenthal, 2006).

> *The people that are our patients, they're not someone we're not going to ever see them again. We're going to see them at school, at the soccer field, we're going to see them all over town. So it's very important for us to provide quality care because we're accountable. We live in the community (Terri, focus group).*

Although personally knowing their patients had a positive influence on their practice, the rural hospital nurse participants also discussed the difficulties associated with this personal connection. As an outsider, I had assumed I would hear nurses discussing the difficulty of having to provide care to a close family member not only when he or she was more "stable" but as well in emergent situations. Even though the nurses in this study were sometimes required to provide care to members of their families in these situations, personally knowing their patients regardless of familial association often resulted in the development of *"strong emotional ties" (Laurie)* that at times made providing nursing care difficult, such as when the patient was dying. While having strong emotional attachments had both positive and negative influences on their practice, personally knowing their patients made maintaining patient confidentiality difficult. Not only did the nurses know the patients, but members of the community knew the nurses who knew the patients. Patients also knew other patients. The interconnectedness between the nurses, patients, and community as a whole influenced how confidentiality was understood and maintained. Indeed while confidentiality implies anonymity, in the rural setting anonymity is most likely not possible and so the notion of privacy where some information is by nature "public," more accurately reflects the experience of confidentiality. *Laurie* seems to capture this notion when she states

> *...in a small town, you might be talking about the guy in ICU and the guy in 2410 figures out who you're talking about. So there's a little bit more emphasis on being careful what you're taking about and how you say it.*

When discussing their community ties, the nurses in this study inevitably spoke of the countless number of times when they were asked *"professional questions"* outside of the hospital *(Mary, focus group)*. Either at the grocery store, post-office, parent school meetings, or when they were dining out, people would ask their opinion and/or advice about health matters, blurring personal and professional boundaries resulting in a lack of anonymity (Raph & Buehler, 2006) as noted by *Angie's* comment.

> *I get a lot of phone calls at home. People I know that I'm a nurse so they phone me. 'My husband froze his ear when he was outside, what should I do?' 'Take him to emergency.' Or you're downtown 'Hey, look at my finger. What's wrong with it?' (Angie).*

"Doing the hermit thing"

For two nurses the lack of anonymity was personally and professionally affirming (Raph & Buehler, 2006). For these nurses being recognized as "the nurse" reinforced for them that the care they provided to the patient while in hospital was outstanding and appreciated.

However, for other nurses having high visibility within the community resulted in having to *"do the hermit thing" (Merissa)*. Their lack of anonymity was perceived as intrusive. So that personal and professional boundaries could be maintained, they left the community as often as possible. While leaving the community was a strategy for those nurses who felt personally threatened by their lack of anonymity (Raph & Buehler, 2006), for the majority of the nurses, being visible within the community was perceived as part and parcel of living in a small town where everybody knows everybody, and emphasized for them their responsibility and accountability. As a professional and role

model with the power to potentially influence the community's health (Bigbee, 1993) they felt they needed to *"walk the talk" (Janie)* to have credibility with their patients and within the community.

The experience of working in the "Dog River" Community Hospital then is rooted in the experience of living in the community of rural "Dog River". Much like the newcomer who has to "learn to be a local," because rural nursing at its core is different than practicing nursing in a rural setting, newcomers to rural hospital nursing practice must learn to practice rural nursing (Scharff, 2006).

Now I want to turn to describing the experience of the students and preceptors before the preceptorship gets underway. In the next domain titled "Dog River" Community Hospital: A great placement," students and preceptors discuss what preceptorship means to them. They speak of the preceptor-student relationship as being central in the learning experience. The main attributes of this relationship are that it is a partnership, a joint effort among all staff members, and requires both students and preceptors conduct a personal inventory. Lastly, what makes a rural hospital a great placement according to the student participants in this study, is being prepared or as they put it "knowing what they are getting into."

"Dog River" Community Hospital: A great placement

As an experienced nurse educator, I believe that clinical experiences are essential in providing students with the opportunity to apply theoretical knowledge gained in the classroom and laboratory setting to "real life" nursing situations (Myrick & Yonge, 2002). I also know that rural hospital preceptorships expose students to the knowledge and expertise of nurses working in a complex and often times ambiguous setting (Yonge,

Ferguson, & Myrick, 2006). Generally, there are 15 requests for rural hospital placements in a class of 100 students (M. Bazin, Clinical Placement Coordinator, personal communication, Jan, 2006). While it is more likely for students who have life experiences and connections in small towns to request this practice setting for their preceptorship (Bushy & Leipert, 2005), in my experience students also request a rural hospital preceptorship because former students indicate that it is "a really good placement."

So what makes "Dog River" Community Hospital and other rural hospitals "a really good placement?" Beyond offering students a wide variety of clinical experiences (Bushy & Leipert, 2005) that might otherwise be unavailable to them, what makes a rural hospital preceptorship an invaluable learning experience is how both nursing students and rural hospital nurses described their experience as a partnership. A partnership implies that both participants share a vision.

> *Preceptorship is definitely the nurse and the student walking together down the road to the common goal of getting that student to the point that she can transition to the graduate role. You have the same goals, you're both there for the same reason, to learn, to help each other and that it is very much a partnership (Sandie).*

Not only do students and preceptors share a vision, but they are committed to each other in achieving the goal of the student successfully *"morphing" (Cassie)* into a graduate nurse (Mitchell, 2005). The importance of building trust and understanding within their relationship contributes to each individual's connecting as partners (McWilliam et al., 2003) thereby optimizing the learning experience.

> *The most important thing for me to do in the preceptorship was to develop trust with my preceptors. To continually show them that I was competent in what I was doing. That I wasn't afraid to ask questions and to take a moment to look something up (Sandie).*

Other attributes that have contributed to the effectiveness of their partnership include: compatibility built on trust and respect noted by *Samantha's* comment, *"we meshed quite well"*; and mutual benefit where, *"I can share my knowledge with the student and she can tell me stuff" (Merissa)*. Equitable power where both were valued and involved in decision making especially when it came to determining learning experiences as noted by *Cassie's* comment, *"my preceptor kind of asked me what I had in mind, what I was interested in, and any skills I wanted to increase my confidence in."*; and adaptability that allowed them to respond to change especially *"when their learning goals weren't being met. We would try to collaborate to make a plan to change that and move in the direction the student was hoping for" (Donna)* were also essential in developing an effective partnership. Lastly, when describing their relationships, the student and preceptor participants in this study identified integrity, patience, and perseverance as attributes that contributed to the effectiveness of their partnership (Mitchell, 2002).

Although all these attributes are important and certainly present in their relationship, what makes "Dog River" Community Hospital and other rural hospitals "a good placement" is the centrality of student/preceptor relationship (Paavilainen & Astedt-Kurki, 1997) evident in the comment *"it's an emotional investment that helps the student and preceptor become a better person and a better nurse" (Daniel)*. To be sure, preceptorship for the preceptors in this study meant that it was an opportunity for both students and preceptors to share in a learning experience that resulted in them learning about nursing practice and themselves as nurses. This is captured in *Angie's* comment *"I felt that I had learned a lot from my student. I took away a lot from that experience."*

Conducting a personal inventory

All of the preceptors in this study indicated that they had chosen to preceptor a student because they enjoyed teaching and wanted to see the student's knowledge and skill improve, and they wanted to promote a career in rural nursing as can by seen by *Mary's* comment *"we want them to come back and work!"* (Shannon, Walker-Jeffreys, Newbury, Cayetano, Brown, & Petkov, 2006). Other factors that motivated these preceptors were that they felt preceptoring a student allowed them to refresh their knowledge and skills, keep current with recent health developments and research, and that it gave them the opportunity to shape the next generation of nurses (Shannon et al., 2006). One administrator expressed that an additional benefit of preceptoring a student was that *"it builds that employee's confidence too" (Terri, focus group)* suggesting that preceptoring is a factor in the development of the professional identity.

Not reported in Shannon, Walker-Jeffreys, Newbury, Cayetano, Brown, and Petkov's findings (2006) that the preceptors in this study indicated was another benefit of preceptoring was that students *"kind of help bridge that gap between older nurses and the brand new grads...preceptoring helps to remind us that learning is a life long thing" (Angie).* Students were seen to bring enthusiasm for learning that had the potential to infect all members of the team regardless of tenure. Although life long learning was a value expressed by those nurses who chose to preceptor, the increased contact with academic faculty who potentially could support their learning and development as a preceptor was not a reported benefit of preceptoring a student (Shannon, Walker-Jeffreys, Newbury, Cayetano, Brown, & Petkov, 2006) and so was not a factor influencing their decision to preceptor.

However, because supervising faculty recognize that preparation for the preceptor role has a positive influence on the outcome of the experience (Charleston & Goodwin, 2004), all of the preceptors in this study were offered orientation to preceptorship in the form of a full day workshop to a few hours with the supervising faculty. Although preceptors have reported that orientation provides practical information aimed at assisting them in their role as preceptor (Charleston & Goodwin, 2004), many preceptors in this study were unable to attend an orientation session because of *"shift work or it was just inconvenient" (Terri, focus group).*

To avoid the emotional and cognitive exhaustion associated with preceptoring (Yonge, Krahn, Trojan, Reid, & Haase, 2002) since it can be *"intellectually and emotionally draining" (Mary, focus group)*, many preceptors limited the number of students they preceptored in the year. This strategy was particularly important when the preceptor had a failing student or one who demonstrated poor clinical performance (Hrobsky & Liners Kersbergen, 2002). In these instances preceptors indicated the experience could *"drag them down if the student didn't have what it took to try and keep up with you" (Daniel)* and so they would *"take a break from students" (Patricia).*

Demonstrating positive emotional intelligence which includes self-awareness (Baltimore, 2004) and the ability to engage in reflective practice (College and Association of Registered Nurses of Alberta, 2007), their decision to preceptor a student was based on an *"internal inventory. [It helped me] decide if I was in a place where I felt I had something positive and not negative to offer my student" (Devon).*

Preceptorship is a joint effort

Although the preceptors in this study demonstrated a positive attitude toward preceptorships, they also discussed some of the barriers they needed to overcome to be effective in their role. Barriers that were *"a bit of a deterrent to be a preceptor" (Donna)* included no reduction in their workload and sometimes an increased workload (Wright, 2002), lack of time to be a preceptor (Yonge, Myrick, Ferguson, & Lughana, 2005), and at times lack of peer and administrative support for their role (Wright, 2002).

> *Sometimes staff think that you have this extra hand so you should be able to handle a heavier workload, which may be the case as you get to the middle of the program and beyond, but early in the program you're actually being a teacher and carrying a workload. It's not like you're two bodies there so you can handle double the workload! Usually we get work added on rather than having it reduced (Donna).*

However, because generally, *"staff are accommodating and facilitating" (Lena)* and *"like to share [their] knowledge" (Merissa)* with students, preceptorships in rural hospitals are a joint venture between the student, preceptor, and staff.

> *I find when there's a student here, the student isn't only under the guidance of the preceptor but most of the staff will take that upon themselves to show the student certain things that they happen to be doing. It's almost like a group preceptorship at times. Everybody kind of gets into a teaching mode (Daniel).*

Countless times students and preceptor participants described instances where the preceptor *"would go down and talk to the girls in emerg and say "My student wants to come down here and do a N.G. so when you have one, phone me and I'll send my student" (Angie).* In keeping with the notion of "we work as a team," students would have the opportunity to work with different staff members including physiotherapists, occupational therapists, and physicians thereby providing them with diverse experiences.

Therefore, because the staff and at least one hospital administrator were perceived to be supportive of the preceptor, preceptors believed students could meet the objectives

of the course and preceptorship, as well as obtain a valid experience of rural hospital nursing practice. Certainly, *Samantha's* comment seems to support the belief that a rural hospital preceptorship provides an invaluable learning experience.

> *I would definitely say that I made a good decision to come out to a rural hospital. It worked for me to have a really broad variety of care. It helped me get the big picture down instead of working on one unit that has a specific focus [where] you don't get the big picture (Samantha).*

Lastly, the preceptors in this study believed they were appropriately skilled for their role and that their workplace benefited from the presence of students (Hsieh & Knowles, 1990). In fact *Mary* (focus group) felt that her skills as a preceptor were so well developed that she "*could tell in the first four shifts what the student was going to be like...if she would get it.*"

Overwhelmingly, rural hospital preceptors including those in the "Dog River" Community Hospital believe that their relationship with the student is central to the success of the experience. Indeed, the relationship has the potential to support the development of a sense of belonging as noted by *Cassie's* comment:

> *I think the value of having a preceptorship in a rural hospital setting is that you just get to develop that closer relationship with the staff. You get to develop close professional and personal bonds with everyone and get to see them on all sorts of levels. You get to interact and support each other and you get to work as a team.*

I'm going to "Dog River": I need to know what I'm getting into!

Typically, students have the opportunity to undertake their preceptorship in an area of nursing practice that is of interest to them. Students who choose a rural hospital setting frequently state one reason they choose this particular setting is because *"there wasn't one place that I knew I wanted to work. So I wanted to work somewhere knowing I*

would have a little bit of everything and that's really what it was" (Linda). They seek a clinical placement that can provide them with diverse experiences.

While the benefits of preceptorship such as increased clinical competency, self-confidence, enhanced critical thinking (Freiburger, 2002; Letizia & Jennrich, 1998; Myrick, 2002a; Myrick, 2002b), as well as easing *"the transition to being out in the real world" (Cassie)* are known to most students, the student participants in this study also knew that being able to establish a working relationship with the preceptor was pivotal to their success. Comments like *"it depends on the preceptor for sure because we weren't that much different in what we were doing or how we were" (Elanor),* and *"our personalities matched" (Samantha)* seem to imply that for students, developing a productive relationship was dependent on sharing some commonalities with their preceptor such as being outgoing, and having congruency of values and expectations (Crawford, Dresen, & Tshikota, 2000). Without these components, *"coping with the ups and downs of being preceptored" (Candace)* would prove to be difficult resulting in a less satisfying experience for both the preceptor and student (Yonge, 1997). For this reason, students needed to *"know what they were getting into" (Janie).*

Student participants in this study have indicated that part of knowing what they were getting into was the articulation of their expectations of the experience and of the preceptor. Being able to identify their expectations of the preceptor allowed both the student and preceptor to develop congruent mutual expectations (Crawford, Dresen, & Tshikota, 2000), thus setting the stage for the relationship to unfold. Generally, students in this study expected the preceptor to be a resource, encourage questions, and provide feedback.

Although faculty members are intrinsically involved in the students' academic program (Myrick & Yonge, 2005), and assist students in preparing for their preceptorship by not only teaching and reviewing relevant theoretical content and psychomotor skills, but as well by preparing them psychologically, student participants in this study perceived faculty as taking on *"much more of a teacher role [where they] do more of the grading because they aren't with you on the floor" (Olive).* Indeed, when asked how the faculty helped prepare them for the preceptorship, many students expressed neutral answers (Yonge & Myrick, 2004) such as, *"my instructor kind of prepared me for the preceptor experience before the ten weeks started by giving me feedback through my assignments" (Sandie).* Thus, student and preceptor perceptions of the supervising faculty role seemed to indicate that they expected faculty members take on a more peripheral role in the students' experience. For *Bob*, a student, the learning experience was perceived as his responsibility noted by his comment. *"I take responsibility for my learning. I'm the one that's transitioning not my instructor. If I was having trouble with it, I would contact my instructor and discuss the issue."* Accordingly, *Donna,* a preceptor, agrees with *Bob* and feels that the preceptorship is an experience between the student and preceptor that requires minimal support from supervising faculty.

> *I probably wouldn't really want too much contact with [the instructors] just because I think at this point in time students should be quite independent and be able to communicate with me if they had concerns and wanted things done differently. I would sooner have that direct line of communication rather than going through the faculty member and then to me. So I would just like contact at the beginning of the program so that I could be aware of any special areas that I could watch for. I know they probably would be hesitant to expose those but just if there was any way to help students overcome an area they could work on that I could be made aware of that so that the student could be more successful. And then in the middle of the program just to make sure I was on track with what the program was wanting. And then maybe at the end of the program if there*

was any feedback on what I had done as a preceptor that could have been better or should have been different.

Contrary to the expectation that nursing educators can and should be a pivotal source of support for students and preceptors especially at the beginning of the preceptorship (Myrick & Yonge, 2005; Hsieh & Knowles, 1990), in this study, student and preceptor participants expected supervising faculty to simply administer the course and offer an orientation to preceptorship to the preceptors.

In their preparation to go to a rural hospital, similar to the preparation some preceptors undertook, student participants engaged in a type of "personal inventory" that included a review of their emotional and psychological, cognitive, and psychomotor abilities (Yonge, 1997). Comments and questions such as:

> *"Am I prepared to do a preceptorship?" (Cassie); "How do I function as a team member?" (Donna); "Be prepared that everybody's going to know everything about you in a week" (Olive); "Be prepared because you're going to be dealing with everything" (Merissa); "Know you're not going to be an expert so don't feel like you have to know everything" (Mary, focus group); "Know that the moving transition is a big thing" (Janie); "Prepare for the level of responsibility but don't be scared" (Laurie);* and *"Do as much as you can to get into the team, be prepared to be left out at first but go that extra mile" (Patricia)*

seem to indicate that preparing for the experience is a complex undertaking. Indeed these comments seem to imply that certain characteristics like you have to *" be a strong individual"(Daniel), " have a fairly sound knowledge base"(Merissa), "be open to learning"(Elanor),* and be able to recognize their limitations and take responsibility for their learning were needed to be successful in this type of placement.

While some students felt they could not really prepare for the experience (Bell, Daly, & Chang, 1997) other students attempted to *"...review everything. I needed to*

know everything" (Candace). Still other students had to consider the impact commuting or relocating to the rural community would have on their financial situation (Neill & Taylor, 2002).

> *Not every student can go to a place that has easy access. Distance is a drawback for many students because they don't have anywhere to stay and some places are half hour, 45 minutes away and that sucks up gas and time. When you're not getting paid for any mileage it can be a financial burden (Bob).*

Although not stated in the literature, these students also discussed the need to guard the learner role. Because some of them had previous working experience in the rural hospital in which their preceptorship would take place, they felt confusion over role expectations was a very real possibility.

> *The manager knew I had worked there before. He knew I could handle a tough workload and when there were shortages. But as a student you should have more teaching rather than be put in as an extra staff member (Janie).*

For preceptors, staff, and they themselves to understand the learner role (Leners, Stizman, & Hessler, 2006) they needed to have a clear understanding of what the student could and could not do according to school, hospital, and professional nursing association policies. As can be seen and in keeping with the findings in the literature pertaining to the preparation of students for the rural experience, students in this study demonstrated that there was no consistent approach or best practice for preparing for the rural preceptored experience (Sedgwick & Yonge, 2007, in press).

Without fail however, all of the student participants in this study have indicated that unlike the experiences of their colleagues in urban centers, they are not *"just a student" (Cassie),* anonymous to the staff. Rather in a rural hospital they are known as people with names and aspirations and goals instead of simply being someone who can get the work done (DeBellis, Longson, & Glover, 2001). In rural hospitals students are

not *"thrown to the wolves" (Katie)* where there is minimal investment in the students' learning. Instead, their relationship with not only their preceptor, but with the other nurses in the hospital, supports a mutual construction of knowledge (Etheridge, 2007) that in turns facilitates their sense of belonging (Winter-Collins & McDaniel, 2000).

I belong in "Dog River"

Overwhelmingly, when I asked the student participants how their experience had gone, I received the following response.

> *It went really, really well! I'm so glad I had the chance to come here. I learned so much more than I expected! My preceptor has been so wonderful and the staff have been awesome. In fact, the staff are asking me not to leave. I feel like I'm part of their team! (Laurie).*

Comments such as *"I was included in the laughing" (Samantha), "I'm not viewed as just a student who's there for her preceptorship" (Sandie), "We embrace them [referring to students]" (Terri, focus group)* and, *"I felt accepted as a staff member on the unit" (Sandie),* reinforce for me the notion that developing a sense of belonging is pivotal for the success of the rural hospital preceptorship. Indeed, these comments seem to suggest that interpersonal relationships had a significant impact the student participants where their sense of belonging in the rural hospital environment is dependent on the strength of their relationship with not only the preceptor, but with the staff as well (Winter-Collins & McDaniel, 2000). Furthermore, the comment, *"I'm a part of their team" (Katie)* suggests that students' identity as professional nurses is in large part determined by being a member of the nursing team.

The importance of being a team member in the rural hospital setting cannot be overstated since the inability to be part of the team has potentially serious consequences. Students indicated they became uncertain of themselves and in their abilities resulting in

"second guessing [themselves]" (Candace) to feeling excluded and isolated as noted by this comment.

> *If you're planning on staying in a rural community being part of the team is more important because you don't have a lot of options. In an urban center if I really wasn't getting along with the team that I was working with or not feeling that I was accepted, I could move to another unit. In a rural hospital you don't have that option. You either become part of the team or you're kind of ostracized (Samantha).*

Indeed, work group cohesion helps alleviate students' sense of helplessness and aloneness, and fosters a sense of connectedness (Hill, 2006). Like new graduates who identify the support that they receive from experienced nurses as invaluable in overcoming "reality shock" (Kramer, 1974), students in this study feel that experienced nurses who *"will teach [them] the tricks of the trade" (Sandie)* assist them in becoming part of the team. Thus, the ability to identify oneself as a group member consolidates and enhances the student's self-worth and produces for the student a coherent sense of identity (Schlachet, 2000). For *Janie* this meant that *"[the staff] treated [her] as an RN. [She] played more of an important role and had a greater role on the team than previously."*

Intrigued by the participants' responses to my question, I asked them how they became part of the team. Both the students and preceptors in this study indicated that part of the work of the preceptorship was to build bridges so that there was less distance, or more precisely that the distance between theory and practice (Myrick & Yonge, 2005), the student and graduate roles (Goldenburg & Iwasiw, 1993), and staff and student was bridged.

Bridging Theory and Practice

Students and preceptors in this study readily identified various roles preceptors assumed while bridging theory and practice. Preceptors were described as guides, facilitators, role models, teachers, negotiators, and even cheerleaders (Myrick & Yonge, 2005). As a facilitator of learning, preceptors created a climate for critical thinking (Myrick & Yonge, 2001) by encouraging questions, providing reassurance, and showing students *"the ropes" (Olive)*. Students also indicated that critical thinking was enhanced when preceptors provided feedback for areas of improvement, as well as on the skills that had been mastered.

Creating a climate supportive of learning and critical thinking, however, was not the sole responsibility of the preceptor. Indeed the staff with whom students interacted with on a daily basis also helped cocreate a climate that promoted the development of critical thinking (Myrick & Yonge, 2001). However, since not all staff members enjoyed teaching students, students quickly learned *"whom you could ask questions" (Angie)*. Furthermore by observing the interactions between staff members, listening to how they spoke of one another, and at times receiving explicit directions regarding interpersonal relationships such as *"my preceptor said right off the bat said, 'Don't trust so and so, and so and so" (Candace)*, students were able to discern if there was a positive learning climate (Myrick, 2002a; Myrick & Yonge, 2001).

While the relationships between the preceptor and staff was vitally important in setting the climate for learning and critical thinking, student participants also had to engage in behaviors that supported the development of a learning climate. Consistently students stated it was important for them to make the preceptor and staff aware of their limitations in knowledge, psychomotor ability, and even scope of practice.

> *I let it be known what I could and could not do and I let that be known from the beginning. My preceptor and the staff all knew that so I think that helped them. I didn't try to do things that I couldn't do (Cassie).*

In this way they gained the team's trust, which in turn allowed them to reach an acceptable level of comfort necessary for critical thinking (Sedlak, 1999). *Laurie* captures it best when she stated:

> *I think that if you're asking for help then you have to learn to trust other people because you can't do it on your own. That would be overwhelming if you're trying to do everything on your own. You'd get overwhelmed!*

Students then demonstrated intellectual humility (Sedlak, 1999) by living the motto, *"If you don't know something you don't assume you know it. You ask!"(Elanor).*

Specific behaviors preceptors engaged in to support critical thinking that in turn helped bridge the gap between theory and practice included: role modeling safe patient care, such as, *"She was just a great model of how if you don't know or aren't familiar with something, a medication or procedure, where to go for resources" (Cassie),* and *"My preceptor was very much if something had to be done she would tell you...she was upfront with things but she would take into consideration where people were coming from" (Linda);* facilitating, such as, *"She would say 'O.k. we've gotten this far in your preceptorship, what else do you need to learn?' "(Laurie);* giving guidance, such as, *"Preceptors really stand by you and guide you even with simple things like giving immunizations, reading the packages first, what needle you should use, stuff like that" (Olive);* and prioritizing, such as, *"Organization. Like I said to my student the biggest thing right now is to make sure you're out of here on time...not to stay three hours after your shift to chart" (Angie)* (Myrick & Yonge, 2002).

While modeling good nursing practice, preceptors also engaged in the teaching strategy of scaffolding reminiscent of the cognitive apprenticeship model (Cope, Cuthbertson, & Stoddart, 2000). As students became more competent in their skills and knowledge, they were given more independence with less direct supervision as noted by this student's comment: *"The next time I could go off and do it on my own. My preceptors kind of let the leash out a little bit longer each day" (Sandie).* Because all of the preceptors were very concerned about *"not overwhelming" (Lena)* the student given the rural hospital setting could be perceived as being complex and often times ambiguous, they sometimes would break the information down into manageable pieces so that students could focus on relevant theoretical knowledge. For example, this student did not have experience with the provision of nursing care for a woman and her baby before, during, and after a cesarean section. Her preceptor helped break the information down into manageable pieces:

> *I've never been involved with a c-section. What do you do? What are the steps I need to carry out? So my preceptor would break it down more. I think she tried to teach me the basics and from there go a little bit more indepth each and every day (Janie).*

In some instances preceptors used hypothetical cases to direct the students' attention to features of the case which they had not noticed. *"My preceptor would actually take me aside and say so what would you do if this happened with this person?"(Linda).* At other times preceptors would provide students with a "dry run" by *"showing me the first time and explaining it and if I needed to see it one more time because I didn't quite get it the first time she would say o.k."(Linda).*

Preceptors engaged in fading (Cope, Cuthbertson, & Stoddart, 2000): they transferred the onus of engaging in critical thinking to the student in a controlled fashion

so that the student could develop an independent, competent practice, thereby bridging theory and practice. Thus, as time and the preceptorship evolved, *"it kind of went from follow the preceptor to working more together and towards the end I was more on my own and she was just kind of on the sidelines"(Cassie).*

Although all students during a preceptorship experience must bridge theory and practice in order to be successful, students in this study had the added dimension of bridging theoretical knowledge of rural nursing to rural nursing practice. Students needed to learn what it was like to be a nurse in a small town like "Dog River". Gaining this knowledge however, was not straight forward since most preceptors did not speak to the students about what it was like to experience lack of anonymity, possessing "private" knowledge of the patient and their family apart from the patient's medical history, caring for family members or friends, and the fluidity and plasticity of confidentiality. For some students, clients' probing questions were sometimes an uncomfortable experience and it took time to become comfortable with the notion that private information even about themselves was often times considered as belonging to the public domain.

> *I know my first week there were a lot of the clients who started asking a lot of personal questions. I would just answer curtly and then move on so when they would ask me where I was from I would say "I'm from another town. Could you tell more about your headaches? (Katie).*

Therefore, students would often bridge the theory and practice of rural hospital nursing by *"listening to staff members talk about their experiences over the years" (Sandie).* Most frequently however, students learned from their own experiences *"the whole culture of working in a smaller centre, the resources you have in a smaller center, and the type of care given in a smaller center" (Bob).*

Those students who commuted from an urban center to the rural setting, or who did not originate from the community in which the preceptorship took place, also learned that being an outsider had implications for their acceptance as a nurse in the rural setting (Bailey, 1998).

> *My surname is common in this area and I know there are a few families with the same surname and that probably would have extended on to if I was related to them but that all kind of stopped there when I said I wasn't from here. I'm guessing that would have been an in to building rapport with some patients especially in emergency. That would have helped me (Cassie).*

These students learned that the practice of rural hospital nursing is rooted in the experience of living in the community. To help bridge the gap between the community and student (Bailey, 1998), preceptors and staff members would *"get them socialized into the whole team and make a connection outside of work as well" (Terri, focus group).*

Bridging Student and Graduate Roles

Change is defined as what is done differently, and transition is defined as the psychological reorientation needed to successfully adapt to the change (Bridges, 1980). When applied to nursing students who are completing their preceptorship, the change is the assumption of the graduate nurse role, and the transition is the reorientation of the life perspective needed to live as a registered nurse (Scholessler & Waldo, 2006a). Student participants in this study demonstrated that they were moving from the ending phase and entering into the neutral zone phase of transition (Scholessler & Waldo, 2006a). The comment, *"I was done with the books, the school aspect" (Janie)* was a common statement that clearly indicated they were ready to leave behind the student role with all its known activities, supports, and limitations. Not surprisingly however, entering into the neutral zone created some confusion when students learned old behaviors no longer

resulted in success and they needed to learn behaviors of the work world (Scholessler & Waldo, 2006b). In fact, all of the students in this study stated that at times, *"you wonder if you do this, is somebody going to help you? You even wonder what the level of responsibility is when you're actually working in this facility" (Katie).* Therefore, learning what nurses are responsible and accountable for when providing patient care was at times contrary to what they expected (Etheridge, 2007).

> *We've gotten into trouble from some doctors phoning and waking them up for stuff we shouldn't have phoned for. So I guess you get to know your doctors and what you can and what you can't do. There's been times when I'll do what they tell me because I don't know my limitations in what I can and can't do. It would just be nice to know that you could phone the doctors and not have a problem but that doesn't happen here (Elanor).*

Interacting with physicians therefore, was often times seen as an intimidating experience and a responsibility they did not seem to expect to have to take on. Consequently, learning to think like a nurse (Etheridge, 2007) was frequently described as *"a huge learning curve!" (Olive).*

Learning to think like a nurse however, also requires confidence (Etheridge, 2007). As a result, both the students and preceptors frequently discussed the students' level of confidence, their judgments and psychomotor skills, and their ability to think and draw conclusions. As the preceptorship progressed and they were given more independence and a more challenging workload, their level of confidence increased. Pivotal moments where students were able to feel successful increased their level of confidence which subsequently assisted them in thinking like a nurse: the psychological reorientation necessary in transitioning from a student to graduate nurse (Etheridge, 2007).

> *I think when you're in situations, when you're still a student you focus so much on what you feel you don't know. But when for example, last week when we had a patient, I walked into his room his respirations were 40 and they were wet, you could hear them. It was my instinct to roll the head of the bed up. It's little moments like that when you think 'oh, I just knew to do that!" I think it's those things that help your inner confidence because you obviously do know something (Sandie).*

Even though professional values are introduced early in the nursing program as part of their professional socialization (Vezeau, 2006) and linked to the psychological reorientation of learning to think like a nurse, student participants in this study engaged in a reappraisal of their role perceptions (Howkins & Ewens, 1999). To bridge the student and graduate roles, students reflected on which professional values they would incorporate into their self-image of being a nurse. Comments such as *"I became a better nurse in terms of how I was working...more responsible, systematic and knowledgeable. I guess more holistic as a nurse" (Janie); "Just caring for people to the best of your ability all the time"(Janie); "You can tell just observing different nurses and their relationships with their patients how you would might do things differently" (Linda);* and, *"I always understood that advocacy was important but I really saw that I was the patient's voice" (Cassie)* indicate that students observed, reflected, evaluated, and engaged in select behaviors that were consistent with their perception and understanding of the graduate nurse role (Howkins, 1999). While most of the students indicated they felt empowered by redefining and reappraising their professional role, at times other students experienced a degree of moral distress (Rodney, Brown, & Liaschenko, 2004) when the ideal practice taught in school and the practice of the work setting were at odds. In situations when the behaviors they observed were not consistent with their own values, they tended to discard those behaviors and were adamant that although they experienced some discomfort in

deviating from *"the way it's done here" (Bob)*, they continued to engage in behaviors that they perceived were consistent with a professional nurse.

> *One of the nurses does things in her own particular way. So I'm discontinuing an I.V. and I like to put a blue pad underneath just in case there's a gush of blood. She came in and said 'No, we don't do that here' and took it away. I'm like what!? This isn't your patient! I'm going to do things my way (Bob).*

While all graduating students must learn to think like a nurse, students who choose to complete their preceptorship in a rural hospital setting also have to learn to think like a rural nurse. For students thinking like a rural hospital nurse meant they needed to recognize rural hospital nursing practice is rooted in the experience of living in the community. Preceptors would help students to think like a rural nurse by incorporating the concepts of "we're it", "we're a team", "we're a family", and "we have ties to the community" in their discussion and practice. For example they would make students feel comfortable by introducing them to all of the team including team members from other disciplines and demonstrating how to establish and maintain professional relationships with neighbors and even at times staff members as noted by this comment.

> *My preceptor tried to teach me not to get involved in kind of the political thing. A bunch of women all working together there's lots of chattering about different things that happen. In a smaller hospital when you don't have as much staff, my preceptor was good about not getting involved with it (Laurie).*

Preceptors also demonstrated how to work within a team. *Katie* expresses what she has learned about team work this way:

> *Probably team work. The biggest thing is just knowing how to work as a team. Respecting the scope of practice and just each other. Becoming friends with people. Knowing them, knowing their limits, and not being condescending when they ask you a question. Everyone is a team member and on one is better than the other. That was the biggest thing I learned.*

Bridging the Gap Between Students and Staff

In this study, students' and preceptors' stories provided support for the importance of recognizing the rural hospital setting as a social, as well as a technical context in which the significance of becoming accepted into the culture of the workplace cannot be overemphasized (Cope, Cuthbertson, & Stoddart, 2000). Indeed

> *it doesn't matter if the student doesn't know how to start an I.V. The team is till going to accept her if she's got a really good sense of humour and personality regardless of the professional tasks she thinks she needs to master to be accepted. It can be other things that determine if she will be accepted" (Devon).*

Becoming a rural hospital nurse then is as much about joining a community of practice represented by qualified rural nurses as it is about learning the technicalities of nursing (Cope, Cuthbertson, & Stoddart, 2000). It was not uncommon therefore, to hear student participants discuss their attempts to gain entry into the community of practice as can be seen by this comment:

> *During the day or night, I'm always asking everyone "do you need some help? Can I do anything for you?" If people do need help then I'll do it. Like I said through my trying to be more involved and always being a team member has helped a lot too (Katie).*

Underlying this comment is the notion that students are not automatically incorporated into the rural practice community and that marginalization and isolation might result when they are rejected for whatever reason (Hay, 1993). There was one example of marginalization and isolation in this study where *Candace* did not feel that she had been accepted as a legitimate member of the community.

> *Living under criticism where you think that you're being criticized and talked about. Like you walk into the room and you felt you were being talked about. I felt a little bit black balled by my preceptor and people were kind of wary about trusting me then. I was expecting some support from the staff but the camaraderie wasn't there (Candace).*

Although being perceived as perhaps lacking characteristics such as being able to demonstrate initiative, confidence, interest, enthusiasm, and friendliness may have had some impact on this student's ability to be accepted as a member of the practice community, becoming part of the team for all of the student participants in this study was also dependent on how well the preceptor was accepted into the practice community. *"If you were with a preceptor that nobody liked, you'd be climbing uphill trying to get to those people to accept you and like you and see you for who are and not for who your preceptor is" (Elanor).* In fact, if the preceptors' relationships with other team members were strained, it would be expected students' relationships with the team would reflect those of the preceptors as noted by *Devon's* comment.

> *If there wasn't anything positive going on in my relationship with the team, why would there be anything positive happening for her and the team? The team really associated the student with me so if they couldn't give a rats ass about me, I'm not sure her relationship with the team would have been positive for her.*

Conversely, if preceptors had good working relationships with their colleagues, acceptance of the students seemed to more readily and easily occur. *"I think it always takes a little while to become one of the team members, but I think it also has helped that I am with a preceptor who's really well respected and that reflects on me" (Katie).* From these comments I have concluded preceptors need to conduct an internal inventory in order to assess if they have the energy, resources, and relationships needed to assist students in bridging the gap with the staff.

Preceptors protect students and the team

For the preceptor participants in this study, once they had decided their relationships with their colleagues would support a preceptorship, to bridge the gap

between the student and staff, preceptors would engage in strategies that would help minimize the disruption in the team's routine as a result of introducing someone unfamiliar with how the team works (Mumford, 1959). Based on their assessment of the student's knowledge and skill level, learning activities were carefully planned and negotiated with other staff members (Fothergill Bourbonnais & Kerr, 2007) so that conflicts could be avoided between themselves, team members, and students. It was important to review with the student their learning objectives and expectations, teach them psychomotor skills not yet mastered as well as how to use pieces of equipment, and most of all provide reassurance by sharing with them

> *those little idiosyncrasies of the unit and staff just to make the student's life simpler. We do things so routinely that I don't even think about them, but it's important for him to know so that he can be successful (Donna).*

Knowing the routine of the facility became an important skill for the student to master so that they could fit in with the daily activities of the team. Preceptors also engaged in observation and vigilance, and in questioning the student and providing them with feedback so that safe patient care could be provided. Appropriate direction in emergent situations and balancing the student's learning needs with the needs of the unit were other strategies used by preceptors to protect the nursing team.

The flip side of the coin is that in some situations preceptor participants explicitly engaged in behaviors that protected the student's role as learner. For example, in one instance the preceptor had to clearly articulate for the staff the student role and its associated functions and responsibilities.

> *Staffing is always an issue. There's always a shortage. I've seen more frequently than not that the student gets taken advantage of and that she's expected to play a role as a staff member on the floor because she gets separated from her preceptor. I just find in this facility that the drug cart*

> *is very much down played as an easy step, anybody can do that, you could train a monkey to do that, just let the student do that we need you to go do this, separate the two so we have more staff. In that regard that's when I become more protective because I'm advocating for my student to ensure that she gets a good learning experience. I don't see how separating us is a good learning experience. I really try to ensure that learning relationship is always intact. I try really hard to advocate for us and wherever I go, she goes (Devon).*

In this situation the preceptor felt her role as preceptor, as well as the student's learner role, were not valued by her colleagues. It is possible the clinical manager may not have planned in advance with the staff ways in which they could support the preceptor and student in their roles (Fothergill Bourbonnais & Kerr, 2007). Given this potential lapse, at times, preceptors were required to be advocates for the learner and preceptor role.

Being a student advocate also required the preceptor participant to shelter (Öhrling & Hallberg, 2001) the student in certain situations. For example, the preceptors in this study explained that because they knew their colleagues as well as they did, they were able to guage their colleagues' receptivity to the student. As a result they did not *"put the student in a position where someone was going to chew her out" (Angie).* If by chance the student did incur a staff member's displeasure, preceptor participants would intervene and try to *"sort things out by reassuring the student that she's going to be able to complete the rotation. You don't want her to go out of here with her head in a spin wishing she had never come" (Lena).*

As well, to ensure students had a safe passage (Fothergill Bourbonnais & Kerr, 2007) through the preceptorship experience, the preceptors in this study were very particular in choosing which staff members would help preceptor the student when they were not at work. They deliberately choose nurses who had similar teaching styles and

approaches to nursing practice as they themselves had in order to provide the student with a consistent learning experience. Furthermore, given the diversity of potential experiences in rural hospitals and the potential for feeling overwhelmed, so that students could solidify their knowledge and skills, preceptor participants felt it was important that they be provided with consistent exposure to one or two areas of nursing practice.

> *I told [my student] that when I left Realynn (another nurse) was going to be her preceptor while I was gone. I'm taking nights off, so she'll have the same consistent nurse for the nights I'm taking off. I just think for her it would be better instead of bouncing from one person to the next because that's a whole bunch of different personalities that she would have to [get used to]. I'd be gone for six nights so that's six different people and that wouldn't be good. But the one nurse that she's going to be with is taking my shifts so she's going to be there for the whole six nights. I just think that it would be good to be in the same area just for continuity of care whichever area of care they get put into. And just because I know the personality of the nurse that's going to look after [my student], they'll be very similar and she's very good at guiding and stuff. She wouldn't bully her or undermining her or pop quiz her to make her feel stupid. She just would guide her like I've been doing. I think it's important to match her up with another nurse with kind of a similar personality to me, nursing care, values and stuff. I think if you have consistency for the first while, you start to feel your own groove and be able to branch out and do things in your own unique way of doing it (Lena).*

Preceptors also provided safe passage by setting, articulating, and supporting students in meeting expectations consistent with new graduate competencies (College and Association of Registered Nurses of Alberta, 2006), thereby assisting them in building self-confidence.

> *I think it's important for these students to have someone that they feel comfortable with that they can go to with any concerns or just when you feel you need a safe place to be. So I think protecting him from the feeling that he doesn't know anything is important. I'm not placing a value judgment on him at all because I am exploring what he knows and his skill level. But, I have seen other nurses where they have basically attacked the school program and they think these students at this level should be able*

> *to function as a full fledged RN and should be able to handle everything that is thrown their way even though they are in a new environment. They're with new people, they don't have the experience that nurses who are RNs have had. There's definitely a lot of people out there like that. So I guess I want to protect him so he doesn't feel overwhelmed and think why did I ever go into nursing, these are horrible people I'm around, I don't know anything, I'll never be a good nurse. I'd just rather build his self-esteem rather than knock it down (Donna).*

As a result, for all of the students in this study, the provision of emotional support by the preceptor was invaluable, thereby illustrating how overwhelming becoming part of the team could be and how nervous most of the students were about being successful (Thomka, 2001).

> *Providing emotional support especially in this clinical because you're in a place that's kind of isolated and looking for support, we have no other classmates on the same unit as us, is really important. To be that venting support, the debriefing kind of thing. [My preceptor] was that for me. She kind of filled that role that probably would have been a classmate if I was in previous clinical. At the end of the day where you kind of debrief with someone you know (Samantha).*

Although there were countless examples of the staff supporting the learning experience which gives way to the notion that the preceptorship was viewed as a joint effort in these rural hospitals, given that preceptors engaged in protective behaviors to bridge the gap between the student and staff, it is also evident preceptors and students required extensive and continual support from not only other staff members, but as well from managers and supervising faculty members (Fothergill Bourbonnais & Kerr, 2007).

The work of being accepted into the team: students need to learn how to fit in

Student participants in this study, believed the first day of the preceptorship had the potential to set the tone for the remainder of the experience, and they were focused principally on the success of their relationship with their preceptor as noted by *Cassie's*

comment, *"My first intention right at the beginning was to make a really good impression on my preceptor."* However, they quickly identified the need to become more effective in relating to other team members (Schoessler & Waldo, 2006b) so that they could fit in (Godinez, 1999). They actively engaged in getting to know the hospital team by learning what team work meant and how the team worked as a unit, seeking and incorporating staff members' feedback into their practice, and sharing personal information with them. Being known as a professional as well as personally then was required to fit in.

> *It's a combination of being known professionally and personally in order to be included in the team. The nurses had to know you professionally because that's the first thing they see. As you build up that professional relationship, then the personal one comes out from that (Laurie).*

More importantly, though, students learned that cohesive teams such as rural hospital teams have strong norms. To be accepted by the team these norms needed to be upheld or the risk was to experience sanctions for nonconformity (Mumford, 1959). One such norm was to *"know your position" (Daniel)* and to remember *"you're the new kid on the block" (Laurie).* Students therefore, could not *"be a know it all" (Samantha),* needed to *"respect people here even if they're not a registered nurse" (Daniel),* and were required to prove to the team *"whether or not [they] could handle it" (Elanor).*

> *The staff is always kind of watching you saying "hum...how's this person going to work out" kind of thing. I think that would happen more in a rural hospital because you're the only new person. They know kind of how everyone else does things but they're wondering how you're going to do things, how you're going kind of fit in sort of thing. With the older nurses you really had to prove yourself to them and it took more to do that. I find myself now that they're more like "Do you want to try this or do you want to do this?" (Laurie).*

Furthermore, students knew if they did not conform to group norms, because their position within the group was tenuous and on the outer fringes of the group, especially at the beginning of the experience, the sanctions placed on them would be severe, such as being ostracized. For much of time then, they *"wouldn't even open [their] mouth" (Elanor)* even though there were times *"that you wanted to jump in because everyone else is doing it and you had the same feelings as they did" (Elanor).* Although it was tempting to engage in the same kind of behavior as other group members, because of their low status (Mumford, 1959) so that they could be liked and subsequently be admitted to the group, it was wise not to become involved in the political activity of the facility.

> *It's difficult as a student when you're trying and striving for acceptance and you want these people to want to work with you and [you] want your 340 hours to go pretty smoothly. I don't think you want to be rocking the boat (Devon).*

Hagerty, Lynch-Sauer, Patusky, and Bouwsema (1993) state that feeling valued is an antecedent attribute for the "sense of belonging." Students in this study indicated they felt valued for their willingness to learn and assist the team in the provision of nursing care. Comments like, *"Oh good I'm glad you're here today" (Bob), "great we got a degree nurse" (Terri),* and *"We couldn't have managed without her" (Mary, focus group)* made at the beginning of the preceptorship helped to develop for students the sense of belonging.

It was less clear, however, that being valued for their knowledge was an antecedent for developing a sense of belonging since students' needed to *"go through that period of time where you have to prove yourself to show that you know your stuff, that you're competent, that you're cool headed when a crisis comes up" (Katie).*

Ultimately the students' desire for meaningful involvement (Hagerty & Patusky, 1995) noted in the comment, *"I wanted more to become part of the team" (Olive)* seemed to indicate that students in a rural hospital preceptorship understood the need to belong in order to be successful in their experience. Admission into the group then helped students gain confidence in themselves (Holtz, 2004), and served to make them feel that they were an integral part of the team (Cantrell, Browne, & Lupinacci, 2005) as can been seen by *Janie's* comment, *"I played a more important role."*

Being unable to develop a sense of belonging resulted in one student feeling uncertain and always second guessing her judgments. As a consequence, her ability to identify herself as a nurse, let alone a rural hospital nurse, was impaired which caused her to reconsider joining the nursing profession. *"To be quite honest, I'd dread coming to work everyday. I even thought about quitting" (Candace).* Thus, the quality of interaction and not the quantity of interaction with members of the team influenced students' sense of belonging (Winter-Collins & McDaniel, 2000).

Supervising faculty's involvement in facilitating the students sense of belonging

Interested in knowing how faculty members support the building of bridges so that students can gain a sense of belonging that seemed pivotal to the experience of being a rural hospital nurse, I asked the participants for their thoughts. Although the unfolding of the teaching-learning process is the faculty member's responsibility (Myrick & Yonge, 2005), not surprisingly all the students and preceptors in this study indicated that it was important for the faculty member to strike a balance between being available to them, and letting them take control of the experience so that together, the preceptor and student could cocreate a climate in which the student could not only learn but thrive as well

(Myrick & Yonge, 2005). For this reason, one of the principle roles supervising faculty were perceived to have is that of ensuring course and learning objectives could be met by establishing and maintaining clear communication with not only the preceptor, but the hosting facility as well. Furthermore, regular scheduled site visits if at all possible, were considered a cornerstone of effective communication and bridge building. Unfortunately in all but one case, students felt there was a lack of support from the supervising faculty member as illustrated in the following comment:

> *I expected my instructor to be kind of like a liaison. I guess I expected her to come see me, take interest in my preceptorship, to meet the people who were helping me make this transition. Those four preceptors take on a big role and that helps out my schooling. Even my preceptors were a little bit surprised that she didn't come and see me at all (Sandie).*

The apparent lack of support from supervising faculty caused concern for these students in two areas. First, they felt faculty members should be able to provide them with feedback if the feedback they received from their preceptor was inadequate in some way, or if they felt they were not receiving the necessary emotional support from their preceptor to bridge the gap between themselves and the staff. However, supervising faculty members were perceived as a peripheral player in the preceptorship experience because of their limited and often times late contact. As a consequence, students felt somewhat isolated in their learning experience, and at a disadvantage compared to their counterparts in urban settings where faculty scheduled regular site visits. For the student participants in this study, faculty members' sincerity and desire for a successful preceptorship (Myrick & Yonge, 2005) was called into question.

The second area of concern for students in this study regarding the lack of supervising faculty members' involvement in the rural preceptorship centered around the

concept of evaluation. Students frequently expressed anger with the apparent power imbalance in how and who would determine their final grade. Although they knew their preceptor would be asked for their input, almost all of the students felt the preceptor's evaluation should have more impact on their final grade.

> *My instructor was kind of useless sometimes because her visits were only 15 minutes long. If you're only going to stay for 15 minutes, why come at all? I thought maybe she should stay for an hour and really get into o.k. do you have any problems, ask all kinds of questions. She's supposed to be grading me but she's only here for 15 minutes. That was my biggest problem. If you're going to be grading me you should be asking me, let's go through the objectives and are you meeting them, are you having problems with anything, what's going on. I don't know how instructors evaluate students because they don't see any practice, it's all administrative stuff (Katie).*

It is essential therefore that supervising faculty demonstrate they value the rural hospital learning experience. By keeping the lines of communication open that support students and preceptors in building bridges and in the evaluation process (Myrick & Yonge, 2005), students, preceptors, and faculty members themselves can have satisfying experiences.

The cultural theme: "Sense of belonging"

In each of the domains presented above, the notion of belonging is central to the participant's personal and social identity (Bornholt, 2000). As noted earlier, rural hospital nursing is rooted in the experience of living in a small community. Because *"people in the community really like knowing their nurses" (Sandie)*, rural hospital nurses belong to the community. Furthermore, because of the diversity of care provided, it is imperative that they work as a team. Cohesiveness of the team is based on knowing each other and the sense of belonging. The professional socialization of nursing students is impacted by

their ability to be known and accepted by the hospital team. Therefore, to transition from the student to graduate role, nursing students need to develop a sense of belonging to the nursing team. Both nurse preceptors and students build bridges between the staff, patients and students; between theory and practice; and between the student and graduate role to assist the student in developing a sense of belonging. Supervising faculty members also have the potential to facilitate the building of these bridges by offering support to students and preceptors through regular communication.

For the nursing student participants in this study, the experience of belonging to community was influenced by their familiarity with the town and its residents. Most of the students in this study had either originated from or grew up in small rural towns, or had previous experience working in either the hospital designated for their preceptorship or in some other small rural hospital as an undergraduate nursing student employee. For those students who choose to return to their "home town" for the preceptorship, their sense of belonging to the community was evident in their discussion. For those students undertaking their preceptorship in a town that they were unfamiliar with, their sense of belonging to the community was perhaps a little more tenuous. To overcome the limitations associated with being a newcomer and perhaps even a transient, in one instance, the hospital team did recognize the student's tentative connection with the community. They deliberately sought to introduce the student to people within the community since they recognized that the nature of rural hospital nursing practice is rooted in living in the community..

Thus, in summary, although not fully explored, these data suggest that rural nursing is a unique practice area rooted in the experience of living in a small community.

Furthermore, they suggest the cultural theme of developing a sense of belonging is central in the experience of undertaking a rural hospital preceptorship. Behaviors student engage in to develop a sense of belonging include: learning rural nursing practice theory and how to think like a rural hospital nurse, and reappraising their professional values within the concepts of "we're it," "we work as a team," "we're family," and "we have community ties." Students also learned that because they were not automatically incorporated into the rural hospital team, they needed to demonstrate initiative, confidence, interest, enthusiasm, and friendliness so that they might be accepted. Finally, students learned to effectively communicate with the team by actively getting to know the hospital team, building their trust, and by sharing personal information with them. Given the work preceptors and students must engage in during a rural hospital preceptorship, for these participants there is quite "a lot going on" at the "Dog River" Community Hospital.

CHAPTER FIVE
IMPLICATIONS

The purpose of this study was to describe the experience of nursing students and preceptors during a rural hospital preceptorship. The cultural theme that connects all of the domains pertains primarily to a sense of belonging. Although a substantial body of knowledge exists on preceptorship and the body of knowledge for rural nursing practice continues to grow rapidly, the findings of this study have implications for the conceptual basis for rural nursing practice, nursing education, and rural research.

Practice

In a study exploring rural nursing theory across the western United States and Canadian border, Winters et. al. (2006) found at least partial support for Long and Weinert's (1989) theoretical work that addresses the health perceptions and needs of rural persons. Concepts of health, self-reliance, choices, and distance were examined and compared with Long and Weinert's (1989) original descriptive theory. The findings of this study validate and expand upon existing rural nursing theory concepts.

Although the notion of belonging is not a new concept for psychologists or sociologists, understanding the sense of belonging and what it means for students and preceptors undertaking a rural hospital preceptorship expands the body of nursing knowledge, especially the theory of rural nursing practice. The data generated in this study supports the notion that a sense of belonging is central to the success of the preceptorship experience and is foundational to rural hospital nursing practice. This has implications for how the context of rural hospital nursing practice is understood by nurse educators, preceptors, and students who choose a rural hospital preceptorship experience.

Education

The findings of this study suggest that student and preceptor preparation, and supervising faculty involvement in a rural hospital preceptorship must be reviewed and revised if the preceptorship approach to clinical teaching is to be an effective strategy in the preparation of our future professional nurses. To begin the discussion on how nurse educators can assist students and preceptors prepare for this experience some suggestions are offered. Suggestions are also offered on how supervising faculty might better meet the needs of both students and preceptors in rural hospitals.

Student preparation

Throughout their nursing program, students are prepared for their clinical experiences through clinical, laboratory, and classroom teaching. These systematic experiences serve to prepare students for the preceptorship where the goal is to consolidate their knowledge of professional nursing practice (Yonge & Myrick, 2007). Although not all student participants had clinical experiences in the rural setting prior to the preceptorship, all the students in this study began their preparation for the rural hospital experience in a four week theory course prior to beginning their preceptorship. During this four week theory course, students reviewed basic psychomotor skills and completed a "rural nursing specialty scenario." Even though students seemed to have ample opportunity to prepare for the preceptorship, the findings of this study suggest that they are inadequately prepared for a rural hospital preceptorship.

One of the challenges identified for the students in this study was determining what knowledge and skills were needed to provide safe patient care and to be successful in the experience. This particular challenge is fitting since undertaking a rural hospital

experience most often results in being exposed to a variety of patient conditions across the lifespan, which at times requires students to review or learn new knowledge. Furthermore, utilizing certain psychomotor skills that are only practiced in the laboratory setting but are required to practice effectively and competently in the clinical setting can be stressful. For this reason, preparation in advanced technical skills may be necessary to be successful in this particular setting (McGregor, 1999).

Another challenge for the students in this study was that of learning what the "real life experience" of being a rural hospital nurse was like. As indicated by some participants learning to cope with the lack of anonymity, caring for family and friends, dealing with the fluid nature of confidentiality, and becoming part of the team seemed to be somewhat unexpected. Furthermore, they also had to learn to guard their student role. Much of the literature that evaluates the success of rural clinical placements suggests that students who have lived and worked in a rural area are more likely to be successful and satisfied with the rural clinical experience (Somers, Strasser, & Jolly, 2007; Edwards, Smith, Courtney, Finlayson, & Chapman, 2004; Neill & Taylor, 2002). Regardless, not all students are psychologically prepared for a preceptorship experience (Yonge & Myrick 2007) much less a rural hospital preceptorship that might be at a considerable distance from the supervising faculty and other support systems. Edwards, Smith, Courtney, Finlayson, and Chapman (2004) suggest that students must possess a certain level of confidence, competence, and self-reflection to be successful in rural placements.

Recommendations

Consistent with the initiative to engage in effective practice, the following recommendations are offered to help prepare students undertaking a rural hospital

preceptorship. Initially and prior to solidifying rural hospital placements, students should be encouraged to submit a letter of interest describing their reasons for requesting a rural placement, and how they believe this placement will meet their learning objectives. Asking them to identify and discuss their psychosocial, psychomotor and cognitive characteristics will help students meet course objectives, and perhaps even avoid disappointment in the placement (Yonge, 1997). It is also essential that transportation, accommodation, and financial and emotional resources are identified to support the successful completion of the practicum.

If feasible, students should be encouraged to visit the site before the preceptorship begins. Prior contact with rural nurses might help students understand that they have adequate skills for a rural hospital placement, and that support and assistance will be available (Edwards, Smith, Courtney, Finlayson, & Chapman, 2004). Furthermore, spending even a short time in the hospital helps students become familiar with their surroundings and provides an opportunity for them to meet the people they are likely going to be working with, reducing the anxiety associated with starting a new clinical experience (Yonge, 1997). Seeing the clinical site might also serve to dispel misconceptions students have regarding rural hospitals, and may help to solidify for them their commitment to the learning experience (Yonge, 1997). Nursing educators should also be aware that although some students might be undertaking their preceptorship in their "home town," they may not know their preceptor. Meeting the preceptor prior to the start of their clinical experience is helpful in reducing their anxiety and identifying their learning needs.

Content

Although the specialty scenario all of the student participants completed prior to starting their preceptorship is quite comprehensive, there are a number of theoretical content areas nurse educators can discuss in the classroom setting that would assist students to feel better prepared for their rural hospital preceptorship. For instance, obtaining information about the community such as: population demographics and characteristics; current health trends and challenges of people living in a rural setting; morbidity and mortality rates; and available health care services and the delivery method of health care services helps students get to know the community and the population (Bushy & Leipert, 2005; Yonge, 1997; McDonough, Lambert, & Billue, 1992). This type of preparation brings into focus the concept of primary health care on which the Canadian health care system is based.

Along with exploring the concept of primary health care in the rural setting, nurse educators can discuss concepts embedded in rural nursing theory. Through this discussion students will gain greater understanding of rural residents' health care needs and how cultural values, norms, and beliefs impact their health. They will also come to appreciate how these values and beliefs, combined with the realities of rural living markedly affect the practice of nursing in rural settings (Long & Weinert, 1989).

The findings of this study indicate for the rural hospital preceptorship to be successful, students must develop a sense of belonging. Because students are not automatically incorporated into the rural hospital practice community, nurse educators should invite students into a discussion on how to become part of the hospital team. The concepts of "we're it," "we're a team," "we're family," and "we have community ties" can provide the foundation for this discussion as well as for the development of specific

strategies to facilitate their acceptance as a member of the team (Cope, Cuthbertson, & Stoddart, 2000). Such strategies might include seeking, incorporating, and giving feedback, learning and recognizing group norms, and learning how to work in a team.

Content pertaining to guidelines for scope of practice, ethical practice and conduct as developed by professional nurse associations should also be provided (Yonge, 1997). Anticipatory guidance can be given to students by questioning and discussing with them strategies they anticipate they will use to maintain personal and professional boundaries, and patient confidentiality considering some information in some nursing settings is considered private, but in the rural hospital setting is considered "public" knowledge.

McGregor (1999) suggests students need to learn about pathophysiology and introductory nursing science. Student participants in this study suggest there are particular areas of nursing knowledge that are essential in order to provide safe and effective nursing care in rural hospitals. For instance, students frequently described shifts with a laboring mother, or the death of a patient, or patients requiring emergency treatment and care as *"total chaos" (Candace).* Although the current scenario students work through prior to beginning their rural hospital preceptorship addresses all of these content areas, as novice learners (Benner, 1984), they may be overwhelmed in the actual setting with the amount of information they need to deal with and are unable to prioritize their nursing care. It may be more prudent for nurse educators to prepare multiple scenarios for students to work through. In this way more emphasis might be placed on each of these areas of nursing practice and students would have the benefit of repetition.

To help students assume the responsibility and accountability required of rural hospital nursing practice, content pertaining to managerial processes can be included in

rural theory courses (McGregor, 1999). Although nursing students study these concepts throughout the four year baccalaureate degree program, it may be necessary to ensure they have mastered this course content so they perceive themselves as having the essential theoretical knowledge required to be preceptored in a rural hospital setting (Yonge & Myrick, 2007).

Psychomotor skills

During their nursing program all students learn psychomotor skills and are given the opportunity to practice them in the laboratory setting. For a variety reasons not all these students have the opportunity to use these skills in the clinical setting. Since it is not possible to provide students with the opportunity to practice all of the possible skills they might use in a rural hospital setting, it is important that nurse educators assist students to master some common advanced technical skills prior to commencing their preceptorship. Examples of such skills include: advanced wound care, monitoring and interpreting basic electrocardiogram readings, conducting cardiopulmonary resuscitation (CPR), and initiating venipunctures (McGregor, 1999). Having experience with particular psychomotor skills helps students understand they have adequate skills and knowledge and adds to their confidence (Edwards, Smith, Courtney, Finlayson, & Chapman, 2004).

Preceptor preparation

Unlike Yonge and Myrick's (2004) findings where preceptors engaged in a variety of methods to prepare for the preceptorship, the findings of this study suggest that apart from conducting a "personal inventory," rural hospital preceptors' preparation is limited. One reason why their preparation is limited may be that they feel they already possess the necessary skills to be an effective preceptor. Without doubt, the preceptors in

this study demonstrated many teaching skills that assist students to develop critical thinking, organizational, psychomotor, and interpersonal skills. Another reason why their preparation might be more limited is that apart from two preceptors, all of the preceptors were experienced preceptors and so more than likely felt prepared to take on the preceptor role.

Regardless of whether or not they were new to their role, an orientation to the preceptorship was offered to all of the preceptors in this study. However, the preceptors in this study also indicated that it was difficult to attend an orientation in the urban centre although they could see the value of attending. Barriers included: travel and accommodation costs, and negotiating time away from work when staffing levels were frequently stretched and they were expected to provide the needed bedside care to patients (Speers, Stzyzewki, & Ziolkowski, 2004). Nurse educators therefore, need to consider alternate modes of delivery for the orientation of rural hospital preceptors.

Recommendations

In a national study, Andrews, Stewart, Pitblado, Morgan, Forbes, & D'Arcy (2005) found rural nurses value face-to-face contact with their colleagues. To provide the preferred face-to-face learning environment, nurse educators might consider offering a preceptorship orientation in collaboration with other professional events nurses attend such as using Nurses' Week to provide a forum for meeting with preceptors. Alternately, based on their assessment of the rural setting, nurse educators might use one or a combination of web-based online chat rooms and postings, written modules, videoconferencing, teleconferencing, or an online program (Phillips, 2006). These types of orientations however, must be designed in such a way that supports interaction among

the participants so that they have the opportunity to share their knowledge and experiences with each other. In this way experienced and novice preceptors can share concerns and strategies related to the preceptor role (McKnight, Black, Latta, & Parsons, 1993). As well, rather than expecting rural hospital preceptors to use their own time to prepare for the preceptorship funded workshops, the provision of technical support for an online orientation, and being given paid time to attend an orientation would indicate the value that is placed on the preceptor role and their contribution to the education of students (Yonge, Myrick, Ferguson, & Lughana, 2005).

Supervising faculty involvement

Although Fothergill Bourbonnais and Kerr (2007) suggest that the visible and continued presence by supervising faculty members through regular visits to the clinical sites in which a preceptorship is being undertaken is crucial to preceptors and students, the findings of this study suggest that faculty involvement in rural hospital preceptorships is minimal and does not meet the needs of the student or preceptor. Sadly, this suggests that for students and preceptors, supervising faculty's involvement in the preceptorship experience had little value and little or no impact on the development of the student-preceptor relationship and student professionalization.

Unfortunately most of the nursing literature focuses on the preparation of the preceptor and student for the preceptorship role (Yonge & Myrick, 2004; Trevitt, Grealish, & Reaby, 2001) even though Myrick and Yonge (2005) stress that the faculty member is the custodian of the teaching-learning process and so is a key player in the preceptorship experience. To ease this discrepancy the following recommendations are

offered to increase the involvement of supervising faculty members during a rural hospital preceptorship.

Recommendations

Faculty accessibility

It is essential that faculty members be a visible and continual presence during the preceptorship experience so students, preceptors, hosting facilities, and supervising faculty members have a successful and satisfying experience (Fothergill Bourbonnais & Kerr, 2007). Supervising faculty, therefore, should begin to establish their accessibility with preceptors before the students begin the preceptorship (Ferguson, 1996). An orientation session may serve this purpose. To supplement contact through orientation, faculty are encouraged to contact each preceptor individually either in-person or by telephone. A benefit of this personal contact is the development of a working relationship with preceptors. Furthermore, since "knowing" the people they work with is a key characteristic in rural nursing practice, personal contact with preceptors will help rural hospital nurses feel that they "know" the supervising faculty member.

The participants in this study suggested that if at all feasible, faculty members should make at least one and preferably more site visits during the preceptorship. While making site visits encourages preceptors and students alike to discuss issues that might have arisen, the preceptors in this study and in other studies (Ferguson, 1996) suggest that supervising faculty should not be on the unit for extended periods of time since this type of supervision could interfere with the development of their relationship with the student. An early visit during the preceptorship would permit students and preceptors to ask questions and perhaps ease any uncertainty they may have about the experience. Follow-

up in-person or telephone visits should be scheduled for a particular amount of time, and should not disrupt client care unnecessarily. Having the same supervising faculty member for several sequential preceptorship experiences would also help establish consistency in the experience and the development of the relationship between the hospital staff, faculty, and educational facility.

Although contacting rural hospital preceptors might most often occur via telephone, with more and more hospitals making Internet access possible for their employees as well as the presence of personal home computers, faculty members can stay connected with preceptors via email. Continued regular contact throughout the experience allows both students and preceptors to ask questions and raise concerns, and allows faculty members to be proactive rather than reactive in the event of an error or problematic situation (Myrick & Yonge, 2005).

To facilitate more on site visits, faculties and schools of nursing need to recognize the time and energy required by faculty members who may be required to travel long distances to support both preceptors and students. In allotting workload to faculty members, there must be sufficient hours allotted to meet with preceptors and students on a regular basis and not just when students make an error or when other problematic situations arise. As an adjunct to site visits, videoconferencing with preceptors and students could be used. Being able to meet face-to-face albeit through the use of multi-media technology can help students, preceptors, and faculty members feel connected and part of a team with a shared goal (Myrick & Yonge, 2005).

McInnis and Wofford (2006) suggest that because direct observation of students by faculty is the gold standard, nurse educators who supervise rural students who are at a

distance from the educational institution must find creative ways in providing supervision. Supervision might include using digital cameras, live-feed video, or audio recorders. Considerations for this type of supervision would include consent from health regions, staff, patients, and their families. Orientation to the equipment as well as a discussion regarding the appropriate use of this type of technology would be required. The financial impact on students, hospital facilities, and the educational institution must also be considered. Lastly, faculty would need to consider and explain to students how this type of data would contribute to the assessment of their practice (Andre, 2000).

Apart from being accessible to the preceptor, nurse educators should also develop an effective interview technique when speaking with preceptors. Allanach (1988) suggests using the following questions to create a dialogue between the preceptor and nurse educator. 1. How are things going with your student? 2. What is your student's strongest characteristic? 3. What is your student's weakest characteristic? 4. What do you plan to do with your student over the next few shifts? These questions identify how the preceptor and student learner roles are being negotiated and actualized, and how the student might perceive the feedback given to him/her. Ultimately, these types of questions might help to clarify for the preceptor his/her expectations and evaluation of the student's performance.

Information provider

Although the preceptors in this study felt they possessed the skill needed to preceptor students, in my own experience as a supervising faculty member, I have found preceptors may still need advice about different strategies that promote effective clinical teaching. To be able to offer this type of support and so that continued dialogue about the

learning trajectory (Myrick & Yonge, 2005) and expectations of student performance can occur (Ferguson, 1996), open lines of communication need to exist (Fothergill Bourbonnais & Kerr, 2007; Yonge et. al, 2002). Faculty members therefore, should take the initiative in connecting with the preceptor and should let it be known that they are available whenever needed.

Aligned with their responsibilities as "custodians of the teaching-learning process and guardians of the orientation process, [faculty] assume ultimate responsibility for the evaluation and final grading of the preceptee's performance" (Myrick & Yonge, 2005, p. 53). To complete this task, supervising faculty must seek ongoing input from the preceptor regarding student performance. In my own experience as a supervising faculty member, preceptors find the evaluation of student performance very stressful. In part, preceptors may feel they have not been properly prepared in competency-based assessment and the tool used by the educational program (Kevin, 2006). Because a lack of understanding can lead to assessments being performed that are based on personal criteria rather than that of the assessment tool (Dolan, 2003), nurse educators must ensure preceptors are versed in the use of the assessment tool.

Orientation to the assessment tool might include a discussion of specific examples of expected student performance for each competency. Educational terminology used within the tool must be explained as well as the curriculum requirements. Further, because the clinical environment in rural hospitals is frequently unpredictable, preceptors must be made aware that assessments should allow for changes in patient acuity or level of complexity (Mahara, 1998). The student's ability to respond to new situations will be determined by his/her level of preparation: therefore, the preceptor must be focused on

what is actually required of the student by the educational facility to meet the course objectives, and less on the clinical problems met on the floor (Kevin, 2006). In light of the unpredictable workload levels rural preceptors might have, nurse educators should discuss strategies for supervision and complementary approaches to assessment, for instance incorporating hospital staff members' feedback into their assessment. Furthermore, because the relationship between the student and preceptor is frequently closer than the relationship between the student and supervising faculty member (Brackenrug, 2004), it can influence the assessment process (Kevin, 2006). The implication here is that nurse educators must prepare preceptors to guard against the development of emotional bias, assist preceptors in developing assessment strategies, and provide support and guidance throughout the assessment process. This type of support might also help lessen concerns students in this study expressed regarding evaluation and grade assignment.

Lastly, supporting preceptors by establishing and maintaining open lines of communication, and by providing necessary information throughout the preceptorship, might help alleviate situations wherein preceptors feel anxious about taking another student due to a previous unsatisfactory experience (Fothergill Bourbonnais & Kerr, 2007). Open lines of communication might also help support preceptors emotionally so that they might avoid feeling cognitively and emotionally drained by the experience as noted by some preceptors in this study.

Student advocate

Despite their strong commitment to the students, preceptors in this study identified the importance of supervising faculty members acting as student advocates in

the rural hospital preceptored experience. They thought faculty members should meet individually with students so that if students did identify problems with them or any other aspect of the preceptorship, students could feel free to bring these to faculty members' attention. Faculty members could then help the preceptors remedy the problems identified. For this reason, supervising faculty should have regularly scheduled appointments with students. Furthermore, so that students can feel free to express their concerns without fear of being overheard, these meetings should be scheduled outside of their work hours and outside of the hospital.

Faculty members should also ensure that preceptors are providing learning experiences at a level consistent with student competencies and learning goals (Ferguson, 1996). For this reason, they should assist preceptors in identifying appropriate and stimulating experiences given that at times rural hospitals may have limited experiences.

Preceptors in this study also indicated they expected active faculty involvement in helping them deal with students *"who don't get it" (Daniel).* Suggesting alternative teaching strategies, and providing the preceptor with assurances that they would be supported by the faculty member if negative feedback needs to be given to the student, is necessary in the development of a mutually satisfying working relationship in which student success is central to the learning experience.

Mentor to the preceptor

Although the preceptors in this study saw preceptoring as an opportunity to develop their teaching skills and felt they were well prepared to take on the role of preceptor, supervising faculty support is still needed and valued (Yonge, Krahn, Trojan, Reid, & Haase, 2002). Faculty, therefore, are encouraged to listen to preceptor concerns,

clarify student performance expectations, assist preceptors to interpret student behaviors, and provide preceptors with reassurance that what they are doing is appropriate and will likely help students learn. Supervising faculty is also encouraged to provide preceptors with feedback on their performance in the teaching role so that they can further develop their teaching skills (Ferguson, 1996). Clearly, to have such involvement in the rural preceptorship experience, supervising faculty workloads must be adjusted. The benefits of having an increased presence by supervising faculty in rural hospitals during a preceptorship is job satisfaction for both faculty and preceptors, and increased ability for students to link theory and practice.

Research

According to Bigbee and Lind (2007) methodological challenges unique to rural health research include inconsistencies in the definition of the term "rural"; diversity in rural and remote areas since rural communities are often more different than alike in the residents lifestyles, cultures, and perspectives; and cultural and social influences such as building community trust, time and travel considerations, and participant confidentiality.

Definitional inconsistency

To overcome the challenge associated with definitional inconsistency with the term "rural," in this study, participants identified themselves as either undertaking a preceptorship in a rural community and/or being a rural resident. This approach permitted the participants to identify something in their reality as being rural, thereby illuminating what rural meant to them. The limitation of using this approach is that it would be virtually impossible to recruit a similar sample. Each individual had a unique perspective

of what rural meant for them that inevitably influenced their experience of a rural hospital preceptorship.

Diversity in rural areas

The challenge of conducting research in various communities is the impact the diversity between communities might have on the findings. In this study, participants originated from a 640, 000 square kilometer geographical area extending from central Alberta to northeastern British Columbia, and the Yukon. Industry varied across the communities. Some communities were farming communities while others relied on gas and oil, or forestry, or tourism. Some communities were at a substantial distance from an urban center while others were closer to large cities. As well, some communities had a predominant Aboriginal population while different ethnicities were predominant in other communities. While the communities had differences, they also shared commonalities. All of the communities were experiencing population and economic growth and so shared similar challenges and benefits associated with this growth.

Although each community was unique in some way which impacted the hospital and health services provided, the focus of this study was the phenomenon of the preceptor-student rural hospital preceptorship. Although the context of the rural hospital was lost, the experience of a rural preceptorship for students and preceptors was similar across geographical locations. Furthermore, I feel confident that although there were differences in the hospital setting, I was able to create a common story line of the students' and preceptors' experiences that resonated with them.

Cultural and social influences

Long and Weinert (1989) suggest rural residents distrust outsiders. According to Bigbee and Lind (2007) this distrust may hamper efforts to recruit rural residents for the purposes of conducting research. In this study, three preceptors were actively preceptoring a student during data generation. The other three preceptors had preceptored within two years from the time the study began. Although distrust may have influenced the decision to participate, it was also likely that lack of interest and time commitment influenced the decision-making of potential participants.

Unique confidentiality issues have also been identified in rural health research (Ricketts, 1999). As noted in the results chapter, staff members know each other very well. It was not unusual for me to learn that some of the participants in this study had shared with other staff members that they were participating in the study. This was evident when upon my arrival at the hospital I would to be given directions to the board room by staff members who indicated they knew the reason for my presence. Consequently, due to the familiarity and lack of anonymity among staff members, maintaining the participants' confidentiality and anonymity while participating in the research study was challenging (Lee, 1998).

Another important cultural influence that impacted this study was that for many of the participants in this study, the prospect of engaging in participant observation was problematic. I was unknown, an outsider, to all of the preceptors and students who were actively participating in the preceptorship. Although I carefully explained to the participants my role in and the purpose of participant observation, they remained uneasy with this aspect of the study. Furthermore, conducting a time-limited project that required quick and easy access to the participants so that trust could be built was particularly

difficult given the participants were dispersed over a large geographical area and the study was undertaken during the winter. It is possible to conclude, therefore, that data gathering was challenging and that mistrust did impact the type of data I was able to generate, consequently affecting the conclusions I have drawn.

One way I reduced the fieldwork time was to conduct interviews using the alternate medium of videoconferencing instead of meeting with participants in-person face-to-face. The introduction of audiovisual technology however, had implications with regard to the data making process, analysis of data, and most of all, on the way the relationship between the participant and I was developed and structured (Graffigna & Bosio, 2006). The degree to which I considered if in-person or videoconferencing mediated interviewing was appropriate was dependent on what I believed were the advantages and disadvantages for this interviewing mode (Shuy, 2001).

Advantages of Videoconferencing Interviews

Videoconference technologies include a variety of telecommunication systems that transmit voice, picture, and data over telephone and/or internet connections. Systems vary in cost and complexity ranging from inexpensive desktop systems to fully integrated classrooms (Chapman & Rowe, 2001). For this project, I was able to videoconference from a fully integrated classroom where technical support was available. All of the participants' videoconferencing sites were located within their local rural hospital. Technical support in the rural hospitals was offered by local administrative staff trained in the use of the videoconferencing equipment.

One of the primary reasons I chose to videoconference whenever possible rather than conducting a telephone interview when in-person interviews were not possible, was

that I believed that with the visual cues available through videoconferencing, the interview would more closely resemble the in-person interview (Sellen, 1995). As a result, I would be able to meet the objective of being able to explore with the participants the meaning of their preceptorship experiences (Dicicco-Bloom & Crabtree, 2006; Warren, 2001).

According to O'Conaill, Whittaker, and Wilbur (1993), the more closely a technology approximates in-person interaction, the closer the conversational style is to in-person interactions. Therefore, using a high-bandwidth of >1024 call speed (kbps) available in a SuperNet connection provided a rich medium where multiple nonverbal and verbal cues, the use of natural language, and immediate feedback were possible (Chapman, Uggerslev, & Webster, 2003).

As in in-person interviews, rapport in the videoconference mediated interviews proceeded through the stages of apprehension, exploration, co-operation, and participation (Dicicco-Bloom & Crabtree, 2006). In fact, regardless if the interview was in-person, via videoconferencing, or telephone, many of the participants in this study indicated they were a little nervous being interviewed. However, none of the participants verbalized concern with the technology. Rather, many indicated they were pleased they could meet me "face-to-face" via videoconferencing. As a consequence, the interviews were more of a friendly conversation (Spradley, 1979), an everyday event where contextual naturalness was obtained (Shuy, 2001). A possible reason the participants in this study exhibited such a high degree of comfort and satisfaction with videoconferencing is that they had experience with the technology, since in rural

hospitals it is common place to have meetings, patient consultations, and learning activities via this medium.

Although there may be concern that videoconference interviews take less time and so might not permit the participant and researcher the opportunity to work through all of the interview stages described above, my experience was similar to Shuy's (2001) findings. There was no substantive difference between in-person, telephone, or videoconferencing modes in the time taken to complete the interview. With the permission of the participants, interviews were booked for a two hour period. Only one videoconference interview lasted significantly longer than the two hour time frame negotiated, and so a second videoconference interview took place.

A second reason videoconferencing was chosen as the medium for interviewing participants was that the cost of in-person interviews was determined to be significantly higher than that of videoconferencing (Chapman, 1999). When a SuperNet connection could be secured, there was no cost. The cost associated with the technical supportperson's work time was subsumed as part of his/her normal work day. Telephone interviews and videoconferences using the Integrated Services Digital Network (ISDN) incurred comparable costs since both use telephone lines and are subject to long-distance telephone call charges. Most of these interviews incurred a cost of approximately $30.00 Canadian. Costs associated with in-person interviews included cost of transportation and accommodation for two or three days. At the time in which the project was undertaken because of the provincial economic climate, securing accommodation was often very difficult and costly, and the price for gasoline had reached an all time high. Another associated cost with conducting in-person interviews I had not foreseen prior to the

beginning of the project, was the impact road and weather conditions would have in traveling to the rural sites. Data generation occurred over a winter season that experienced a 30-year record breaking high in the amount of precipitation (snow fall). It was not uncommon for local police and the provincial motor association to issue travel warnings that could have resulted in having to secure lodging for another night adding to the overall travel cost. Accordingly, several interviews were the postponed and/or cancelled resulting in significant inconvenience for both the participants and myself.

Disadvantages of Videoconferencing Interviews

Although there are not many disadvantages to using videoconference technology for conducting qualitative interviews, the disadvantages that do exist require discussion and consideration. In any qualitative study, data making and analysis occur simultaneously. As analysis proceeds, deliberate or focused sampling is necessary to validate or compare data so that the entire phenomenon under study is represented. Those cases that do not support or refute the developing theory are sought. Interviewing participants with a substantially different experience might be more difficult when using videoconferencing than in-person because of the lack of the physical presence of the researcher (Shuy, 2001; Sellen, 1995).

Because physical presence is naturally more intimate, for those participants who have sensitive information and difficult experiences to share, the lack of the physical presence of the researcher may have a negative influence on the degree of sharing. In this project, one participant experienced painful memories associated with her preceptorship. By being physically present, I was able to communicate acceptance and support of the participant by using open body language. As well, I was able to communicate caring and

compassion by offering tissues, rest periods, and the occasional physical touch of the hand or shoulder. Although compassion can be expressed through tone of voice and nonverbal facial expressions through videoconferencing, none of the behaviors that rely on tactile sensation could be expressed through this medium. I am uncertain interviewing this particular participant using videoconferencing technology would have resulted in a level of trust necessary for in-depth sharing to occur. Subsequently, there most likely would have been an impact the type of data generated and on its analysis.

A second disadvantage associated with videoconferencing deals with the quality of call speed (kbps). ISDN connections generally have slower call speeds (128-384 kbps) than do SuperNet connections (>1024 kbps). At the present time, not all rural sites in Alberta, British Columbia, and the Yukon have SuperNet connections and so ISDN connections were used. Similar to other researchers' findings (O'Conaill, Whittaker, & Wilbur, 1993), I found low-bandwidth ISDN connections resulted in poorer image quality and transmission lag. As a result, sudden movements appeared jerky and blurred. As well, depending on the camera angle and how the participant was sitting, at times the participant's face was less clear reducing my ability to see his or her facial cues and establish eye contact. Most often however, the participant's image was displayed from the waist up. This view restricted my ability to observe some nonverbal behavior such as restless legs and crossing or uncrossing of legs (Chapman & Rowe, 2001).

A final disadvantage of using videoconferencing was the availability of the technology. When the project began a provincial service did not exist that could be accessed for booking videoconference meetings. The lack of a provincial service meant the technical support person from the my home site had to contact some rural sites

several times in order to confirm the booking and to perform a test run to ensure the connection would be stable. Setting up of the videoconference was time intensive and often resulted in taking from a few days to weeks to confirm the booking. At times even after confirming the booking, the videoconference would be cancelled on short notice by the rural site because meetings with higher priority, presumably a videoconference pertaining to the provision of health care, would be required during the same time frame. The establishment of a provincial program called Videoconferencing Service late in the project helped to reduce the amount of work for the technical support person by readily providing information regarding videoconference availability reducing the number of conflicting meeting times.

Recommendations for conducting rural research

Although the purpose of this study was not to explore rural communities as such, there were variances between the communities in which the preceptorship was undertaken. Given that rural residents and health care professionals are influenced by their experience of rurality and so may have a different definition of health (Long & Weinert, 1998) than even their counterparts in other rural settings (Bigbee & Lind, 2007), it is possible the findings of this study might have been different if only one or two comparable hospital sites were used to explore the experience of a rural hospital preceptorship. Therefore, if possible, rural communities that are comparable in distance from an urban centre, industry, population, and number of hospital in-patient beds as well as ability to host only one preceptored student at a time should be used so that findings can be more readily generalized to comparable rural hospital preceptorships.

Based on my experience, videoconferencing proved to be an exeellent medium to conduct face-to-face interviews with participants who were geographically dispersed and who would otherwise be interviewed only by telephone. For this reason, based on the type of participant and their needs, videoconferencing is recommended for interviewing participants in rural and remote areas when in-person interviews are not possible or feasible. However, the researcher must consider that participants who will be sharing particularly sensitive information or difficult experiences may share more readily and to a greater degree in an in-person interview where the researcher is physically present.

Similar to Winters and Winters (2007) findings, the greatest level of satisfaction with videoconferencing occurred for both the participants and me when a high-bandwidth connection such as SuperNet was used. If the SuperNet is unavailable, the call speed of the available system should be 1024 kbps or more so that high quality images are received and shorter transmission lags occur resulting in a conversation similar to in-person interactions.

Videoconferencing also proved to be reasonable in cost and drastically reduced the cost of conducting research in the rural setting. As technology advances, it might be feasible to consider video chat also known as web conferencing, which is a two-way full video and audio conversation using Internet Protocol (IP) technologies through personal computers (Annetta, 2005). Such technology would eliminate the need for the technical support currently required for videoconferencing, further reducing costs. Furthermore, availability concerns would be alleviated since the connection is between personal computers and would not be affected by the need to have the technology available for other purposes.

Limitations

All studies have limitations. This study is no exception. As I reflect on the limitations of this study, three limitations in particular need to be discussed. The first limitation is the lack of data generated from participant observation. Although focused ethnographies allow researchers to use only a few strategies in generating data, being able to observe how preceptors, staff, and students use the physical environment of the rural hospital unit would have added depth and breadth to the findings of this study.

The second limitation I have identified that needs discussion is the lack of faculty participation in this study. Because the findings of this study have a significant impact on our understanding of the role of supervising faculty, including data from the faculty members' perspective would add to our understanding of the preceptored rural hospital experience for both students and preceptors, and the professional socialization of nursing students.

Lastly, although methodological coherence was achieved by having the participants identify themselves as being rural or going rural, there may have been some definitional inconsistencies between participants in defining the term "rural." Furthermore, because of my own financial and time constraints, before beginning the study I had identified the geographical area I would be able to recruit potential participants. As a result, there was wide variation among the participants' geographical location. The experience of being suburban, rural, remote, and northern remote might have had impact on the findings. Thus a predetermined definition for the term "rural" as part of the inclusion criteria might result in participants undertaking a rural hospital preceptorship in similar small towns and hospitals. Their experience of being rural might

also be more consistent permitting the researcher to make generalization of the findings and conclusion to similar settings.

Further research

As the body of rural nursing practice knowledge expands, it has come to be understood as unique area of nursing practice. However, understanding the rural preceptor and student experience of a preceptored hospital experience is only just starting to be investigated. The preceptors and students in this study seem to indicate that the preceptorship experience had been successful when the student had become part of the team and felt that they belonged. In light of this study's findings, further research is needed that explores the cultural theme "sense of belonging" during rural hospital preceptorships. Further studies may continue to add to nurse educators, preceptors, and students' knowledge of not only rural hospital preceptorship, but rural hospital nursing practice.

Both the student and preceptor participants in this study indicate the preceptorship has the potential to develop into a mentor relationship. Further studies are needed to explore under which conditions this might happen.

Further, preceptorship in this study was frequently described as a "joint effort." This suggests that although staff members do not plan to be preceptors, they frequently take on the role of preceptor similar to the notion of "the accidental mentor" (Mills, Francis, & Bonner, 2007), because of the nature of rural hospital nursing practice. Further research exploring the experience of being "the accidental preceptor" is needed to better understand the experience of rural hospital preceptorship.

Key players in the preceptorship model in most nursing programs include students, preceptors, staff, and faculty (Myrick & Yonge, 2005). Preceptorships generally offer a one-on-one learning experience where one student is assigned to one registered nurse for a predetermined length of time. In light of the nursing shortage and the demand for quality clinical placements, nursing programs are beginning to establish clinical learning units as an alternate model to meet their clinical placements needs (Henderson, Twentyman, Heel, & Lloyd, 2006). Given the development and establishment of different clinical teaching models including nurse externships, residencies, and mentorships, it is imperative that these are evaluated through research for their contribution and effectiveness in assisting students make the transition to the graduate role.

Although the preceptor participants in this study seem to indicate they felt prepared and possessed the necessary skills to preceptor a student, it is also evident they require support from the supervising faculty. Further research is needed to explore the type of support that rural preceptors might want and need. As well, research is needed to explore the differences between the needs of more experienced preceptors and those who are new to the role.

The findings of this study also seem to suggest that further research on the faculty role in rural preceptorships is required. An exploration of how faculty members understand and operationalize their role during a preceptorship that is at a distance from the educational facility would assist nursing programs in identifying the types of support required of their faculty involved in distant clinical education.

Finally, because there are definitional inconsistencies in rural research, further studies are needed that explore preceptorship in suburban, rural, and remote settings.

Conclusion

This study began with a broad question about how undergraduate nursing students were professionally socialized during a rural hospital preceptorship. Not only did the question lead to findings that support the notion that preceptors, students, and rural hospital staffs use a variety of strategies to help the student transition into the graduate nurse role, but as well, it identified the importance of belonging to the hospital team. The notion of "a sense of belonging" was in fact central across all domains and particularly in determining if the experience was successful in assisting students to become graduate nurses.

This study has demonstrated that the rural hospital setting is invaluable in the professional development of nursing students. Understanding the interplay between the clinical placement and the professional socialization of students can assist nurse educators, preceptors and students in preparing for and learning in this particular setting. Additionally, describing factors that influence students' professional socialization, enhances the effectiveness of this model as a teaching strategy. The findings from this study bridge the realms of nursing theory, education, and research and contribute to the growing body of rural hospital nursing practice knowledge.

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HEALTH RESEARCH ETHICS APPROVAL FORM

Date: June 2006

Name of Applicant: **Dr. O. Yonge**

Organization: **U of A**

Department: **Faculty of Nursing**

Project Title: **A focused ethnography of preceptorship in rural hospitals**

The Health Research Ethics Board (HREB) has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the subject information letter and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval. Written notification must be sent to the HREB when the project is complete or terminated.

Special Comments:

JUN 2 8 2006

Dr. Glenn Griener, PhD
Chair of the Health Research Ethics Board
(B: Health Research)

Date of Approval Release

File Number: B-340606

Appendix B
Information Letter to Nursing Students and Preceptors

Investigator:
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Edmonton, Alberta
T6G 2G3
Phone: 780-539-2896
780-814-4915

Co-investigator:
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Professor and Vice-Provost (Academic Programs)
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Co-investigator:
Dr. J. Spiers, RN, PhD
Assistant Professor
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6th floor Clinical Science Building
University of Alberta
Edmonton, Alberta
T6G 2G3
Phone: 780-492-9821

Factors Influencing the Professional Socialization of Baccalaureate Nursing Students in a Preceptored Rural Hospital Setting

Introduction:
My name is Monique Sedgwick. I am a doctoral student studying the norms, values, beliefs, and behaviors that influence senior nursing students' socialization during a rural hospital preceptorship. Preceptorship is a popular way in nursing programs to offer clinical experiences. They are valuable learning opportunities. Researchers report that there are many benefits to preceptorship. However, the impact of the rural hospital setting on students' professional socialization during preceptorship has not been studied.

You are being asked to take part in this study. I feel you have important information you could share with me that would increase my understanding of your experience.

Purpose of the study:
My goal is to identify and describe factors that influence nursing students' socialization during their senior preceptorship in rural hospitals.

I will collect data by:

1. Interviewing nursing students who are willing to talk about their preceptorship in a rural hospital.
2. Ask the participants to write in a scribbler or a computer document their thoughts, experiences, and feelings about their preceptorship in a rural hospital. The scribbler or computer document will be shared with me.
3. Observing selected activities the student carries out during his or her clinical experience.
4. Talking with other people (student's preceptor, other nurses, staff, and/or patients and their family) about what might influence nursing students' experience of becoming professional nurses.
5. Interviewing preceptors who are willing to talk about the experience of preceptoring a nursing student in a rural hospital.
6. Interviewing nursing instructors about their experience of nursing students' professional socialization during a rural hospital preceptorship.

Procedures:

What will happen?

- Nursing students, preceptors, and nursing instructors will be invited to discuss their experiences with me during an interview.
- Interviews will last no more than 2 hours. We will decide when and where the interview will take place. Generally the interviews will be scheduled outside of work and outside the hospital.
- All interviews will be taped. After each interview, the tape will be sent to a secretary to be typed up word for word.
- At any time during the interview, you can ask to stop or not answer a question. You will be encouraged to talk about anything you have experienced, or thought, or felt during your preceptorship.
- Some nursing students and preceptors that have been interviewed once may be asked for another interview. The purpose of the second interview will be to make clear points from the first interview, or explore key ideas in more depth.
- You might be asked for another interview once the practicum is finished and you have returned to the university.
- Nursing students and preceptors will also be asked to write about their experience. These thoughts will focus on the norms, values, beliefs, and behaviors that have influenced them during the preceptorship.
- Some students will be observed during a regularly scheduled hospital shift. At the beginning, I will observe all of the activities the nursing student engages in. More focused observations based will be collected as the study moves forward.

Consent

- All nursing students, preceptors, and nursing instructors who participate in this study must give voluntary consent.
- You are free to say yes or no to any part of the study.
- You can stop the interview at any time.
- You can refuse to be observed during particular activities.
- I will explain what will happen during each part of the study.

- You are encouraged to ask me to clarify any part of the study that is unclear to you.
- As the study moves forward, I will ask you for your consent before scheduling another interview.
- Taking part in the study will have no effect on your course grade, or on your employment.
- There will be no effect on your course grade or employment if you decide to drop out of the study.
- If you feel pressured, or in any other way uncomfortable with any part of the study, you have the right to contact my supervisors, Dr. Yonge (780-492-2280) or Dr. J. Spiers (780-492-9821) at any time.

Discomforts or risks

- No known discomforts or risks are expected because of your participation in this study.
- If at any time you feel uncomfortable, or you need a break, or need to stop completely, you may do so.
- If during my clinical observation time, I feel a patient and/or family is at risk, I will stop my observations. I will bring to your and your preceptor's attention the issue in the care being provided.

Costs

There are no known costs to you for participating in this study.

Benefits

- You will not be paid to participate in this study.
- You might develop greater understanding of your experience of becoming a professional nurse.
- The information collected will help students, preceptors, and nursing instructors better prepare students who, in the future, choose a preceptored experience in a rural hospital.
- The information will also help nursing instructors understand how the clinical placement and the professional socialization of students during a preceptorship influence each other.
- The findings of this study might explain the relationship between the placement experience and the professional socialization of student nurses. Understanding their interaction is an important step towards improving the effectiveness rural preceptorships.

Confidentiality and Anonymity

- All information will be held confidential (private) except when professional codes of ethics or legislation (the law), requires reporting.
- For this study, small examples of dialogue, or descriptions of observations may be used in publications and presentations. Only my committee members and I will have access to the study transcripts and notes related to you.

- Only I will know your name. You will be identified on transcripts by a false name. Any other information that may identify you will be changed.
- Signed consent forms and personal information will be stored separately in a locked cabinet.
- Your name or identifying information will not be used in any presentation or publication.
- The information gathered for this study will be kept for at least five years after the study has been completed.
- The information gathered for this study might be looked at in the future to help answer other questions related to this study. In such cases, other researchers may need to access your information. However, before they will be able to proceed, an ethics board will first review the new study to ensure your information is used ethically.

Freedom to withdraw

You may at any time withdraw from this study. You do not need to give a reason. There is no penalty for withdrawing. There will be no effect on the outcome of the course, or your employment.

Future use of data

A report in the form of a dissertation will be written about the study. Findings will be presented through journal publications, workshops, and conferences. A summary of the study will be made available to those students and preceptors who make a request.

Additional contacts

If you have any questions, concerns or comments about this research, you can contact Monique Sedgwick (780-539-2896), Dr. Olive Yonge (780-492-2280), or Dr. Jude Spiers (780-492-9821). If you have any further concerns about the research study, you can contact Dr. C. Newburn-Cook, Associate Dean: Research, Faculty of Nursing (780-492-6764), or Dr. Glenn Griener, Chair of the Human Research Ethics Board, Panel B (780-492-0459).

Thank you for your time and consideration.

Monique Sedgwick, RN, PhD(s)

Appendix C
Information Letter to Registered Nurses

Investigator:
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Factors Influencing the Professional Socialization of Baccalaureate Student Nurses in a Preceptored Rural Hospital Setting

Introduction:
My name is Monique Sedgwick. I am a doctoral student studying the norms, values, beliefs, and behaviors that influence senior nursing students during their experience of becoming professional nurses while undertaking a preceptorship in a rural hospital. Preceptorship is a popular way in nursing programs to offer clinical experiences. They are valuable learning opportunities. Researchers report that there are many benefits to preceptorship. However, the impact of the rural hospital setting on students' professional socialization during a preceptorship has not been studied.

Because you have direct experience with being preceptored or precepting in a rural hospital, you are being asked to take part in this study. I feel you have important information you could share with me that would increase my understanding of nursing students' experience in a rural hospital.

Purpose of the study:
I hope to identify and describe factors that influence students' professional socialization during their senior preceptored clinical experience in a rural hospital.

I will collect data by:

1. Interviewing registered nurse who are willing to talk about their preceptorship experience in a rural hospital.

Procedures:

What will happen?

- Registered nurses will be invited to discuss their experiences with me during an interview.
- Interviews will last no more than 2 hours. We will decide when and where the interview will take place.
- The interview will be taped. After the interview, the tape will be sent to a secretary to be typed up word for word.
- At any time during the interview, you can ask to stop or not answer a question. You will be encouraged to talk about anything you have experienced, or thought, or felt during the preceptorship.
- Some registered nurses who have been interviewed once may be asked for another interview. The purpose of the second interview will be to make clear points from the first interview, or explore key ideas in more depth.

Consent

- All registered nurses who participate in this study must give voluntary consent.
- You are free to say yes or no to any part of the study.
- You can stop the interview at any time.
- I will explain what will happen during each part of the study.
- You are encouraged to ask me to clarify any part of the study that is unclear to you.
- If you feel pressured, or in any other way uncomfortable with any part of the study, you have the right to contact my supervisors, Dr. Yonge (780-492-2280) or Dr. Spiers (780-492-9821) at any time.

Discomforts or risks

- No known discomforts or risks are expected with this study.
- If at any time you feel uncomfortable, or you need a break, or need to completely stop, you may do so.

Costs

There are no known costs to you for participating in this study.

Benefits

- You will not be paid to participate in this study.
- You might develop greater understanding of the nursing students' experience of becoming a professional nurse.

- The information collected will help students, preceptors, and nursing instructors better prepared students who, in the future, choose a preceptored experience in a rural hospital.
- The information will also help nursing instructors understand how the clinical placement and the professional socialization of students during a preceptorship influence each other.
- The findings of this study might explain the relationship between the placement experience and the professional socialization of student nurses. Understanding their interaction is an important step towards improving the effectiveness of rural preceptorships.

Confidentiality and Anonymity

- All information will be held confidential (private) except when professional codes of ethics or legislation (the law), requires reporting.
- For this study, other than small examples of dialogue may be used in publications and presentations. Only my committee members and I will have access to the study transcripts and notes related to you.
- Only I will know your name. You will be identified on transcripts by a false name. Any other information that may identify you will be changed.
- Signed consent forms and personal information will be stored separately in a locked cabinet.
- Your name or identifying information will not be used in any presentation or publication.
- The information gathered for this study will be kept for at least five years after the study has been completed.
- The information gathered for this study might be looked at in the future to help answer other questions related to this study. In such cases, other researchers may need to access your information. However, before they will be able to proceed, an ethics board will first review the new study to ensure your information is used ethically.

Freedom to withdraw

You may at any time withdraw from this study. You do not need to give a reason. There is no penalty for withdrawing. There will be no effect on your employment.

Future use of data

A report in the form of a dissertation will be written about the study. Findings will be presented through journal publications, workshops, and conferences. A summary of the study will be made available to those registered nurses who make a request.

Additional contacts

If you have any questions, concerns or comments about this research, you can contact Monique Sedgwick (780-539-2896), Dr. Olive Yonge (780-492-2280), or Dr. Jude Spiers (780-492-9821). If you have any further concerns about the research study, you can contact Dr. C. Newburn-Cook, Associate Dean: Research, Faculty of Nursing

(780-492-6764), or Dr. Glenn Griener, Chair of the Human Research Ethics Board, Panel B (780-492-0459).

Thank you for your time and consideration.

Monique Sedgwick, RN, PhD(s)

Appendix D
Information Letter to Nursing Instructors

Investigator:
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Co-investigator:
Dr. J. Spiers, RN, PhD
Assistant Professor
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6th floor Clinical Science Building
University of Alberta
Edmonton, Alberta
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Phone: 780-492-9821

Factors Influencing the Professional Socialization of Baccalaureate Student Nurses in a Preceptored Rural Hospital Setting

Introduction:
My name is Monique Sedgwick. I am a doctoral student studying the norms, values, beliefs, and behaviors that influence senior nursing students' socialization while in a rural hospital preceptorship. Preceptorship is a popular way to offer clinical experiences. They are valuable learning opportunities. Researchers report that there are many benefits to preceptorship. However, the impact of the rural hospital setting on students' professional socialization during a preceptorship has not been studied.

I am sending this information letter to you so that you might increase your students' awareness of this study.

You are also being asked to take part in this study. I feel you have important information you could share with me that would increase my understanding of nursing students' experience in a rural hospital.

Purpose of the study:
I hope to identify and describe factors that influence nursing students' professional socialization during their senior preceptorship in a rural hospital.

I will collect data by:

1. Interviewing nursing students who are willing to talk about their preceptorship in a rural hospital.
2. Asking the participants to write in a scribbler or a computer document their thoughts, experiences, and feelings about the preceptorship in a rural hospital. The scribbler or computer document will be shared with me.
3. Observing selected activities the student carries out during his or her clinical experience.
4. Talking with other people (students' preceptor(s), other nurses, staff and/or patients and their family) about what might influence nursing students' experience of becoming a professional nurse.
5. Interviewing preceptors who are willing to talk about the experience of preceptoring a nursing student in a rural hospital.
6. Interviewing nursing instructors about their experience of nursing students' professional socialization during a rural hospital preceptorship.

Procedures:
What will happen?

- Nursing students, preceptors and nursing instructors will be invited to discuss their experiences with me during an interview.
- Interviews will last no more than 2 hours. We will decide when and where the interview will take place.
- The interview will be taped. After the interview, the tape will be sent to a secretary to be typed up word for word.
- At any time during the interview, you can ask to stop or not answer a question. You will be encouraged to talk about anything you have experienced, or thought, or felt during the nursing students' preceptorship.

Consent

- All nursing students, preceptors, and nursing instructors who participate in this study must give voluntary consent.
- You are free to say yes or no to any part of the study.
- You can stop the interview at any time.
- Should you be present at the time I am observing a particular student, you can refuse to be part of my observations.
- I will explain what will happen during each part of the study.
- You are encouraged to ask me to clarify any part of the study that is unclear to you.
- If you feel pressured, or in any other way uncomfortable with any part of the study, you have the right to contact my supervisors, Dr. Yonge (780-492-2280) or Dr. Spiers (780-492-9821) at any time.

Discomforts or risks

- No known discomforts or risks are expected with this study.
- If at any time you feel uncomfortable, or you need a break, or need to completely stop, you may do so.

Costs

There are no known costs to you for participating in this study.

Benefits

- You will not be paid to participate in this study.
- You might develop greater understanding of the nursing students' experience of becoming a professional nurse.
- The information collected will help students, preceptors, and nursing instructors better prepared students who, in the future, choose a preceptored experience in a rural hospital.
- The information will also help nursing instructors understand how the clinical placement and the professional socialization of students during a preceptorship influence each other.
- The findings of this study might explain the relationship between the placement experience and the professional socialization of student nurses. Understanding their interaction is an important step towards improving the effectiveness of rural preceptorships.

Confidentiality and Anonymity

- All information will be held confidential (private) except when professional codes of ethics or legislation (the law), requires reporting.
- For this study, other than small examples of dialogue, or descriptions of observations may be used in publications and presentations. Only my committee members and I will have access to the study transcripts and notes related to you.
- Only I will know your name. You will be identified on transcripts by a false name. Any other information that may identify you will be changed.
- Signed consent forms and personal information will be stored separately in a locked cabinet.
- Your name or identifying information will not be used in any presentation or publication.
- The information gathered for this study will be kept for at least five years after the study has been completed.
- The information gathered for this study might be looked at in the future to help answer other questions related to this study. In such cases, other researchers may need to access your information. However, before they will be able to proceed, an ethics board will first review the new study to ensure your information is used ethically.

Freedom to withdraw

You may at any time withdraw from this study. You do not need to give a reason. There is no penalty for withdrawing. There will be no effect on your employment.

Future use of data

A report in the form of a dissertation will be written about the study. Findings will be presented through journal publications, workshops, and conferences. A summary of the study will be made available to those students, preceptors, and nursing instructors who make a request.

Additional contacts

If you have any questions, concerns or comments about this research, you can contact Monique Sedgwick (780-539-2896), Dr. Olive Yonge (780-492-2280), or Dr. Jude Spiers (780-492-9821). If you have any further concerns about the research study, you can contact Dr. C. Newburn-Cook, Associate Dean: Research, Faculty of Nursing (780-492-6764), or Dr. Glenn Griener, Chair of the Human Research Ethics Board, Panel B (780-492-0459).

Thank you for your time and consideration.

Monique Sedgwick, RN, PhD(s)

Appendix E
Consent Form

Factors Influencing the Professional Socialization of Baccalaureate Student Nurses in a Preceptored Rural Hospital Setting

Investigator:
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Co-investigator:
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Professor and Vice-Provost (Academic Programs)
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Co-investigator:
Dr. J. Spiers, RN, PhD
Assistant Professor
Faculty of Nursing
6th floor Clinical Science Building
University of Alberta
Edmonton, Alberta
T6G 2G3
Phone: 780-492-9821

Do you understand you have been asked to take part in a research study? Yes No

Have you received and read the Information Letter? Yes No

Do you understand the benefits and risks involved in taking part in this research study? Yes No

Have you been able to discuss or ask questions about this study? Yes No

Do you understand that you are free to pull out from this study at any Time, and that you do not have to give a reason? Yes No

Do you understand that you are free to not answer any question, and that you do not have to give a reason? Yes No

Do you understand taking part in this study will not directly benefit you in any way? Yes No

Has the way your identity will be protected been explained to you? Yes No

Do you understand you will have access to the information you provide? Yes No

Do you understand your name will not be connected with any information you provide and that all identifying information will be removed from the records? Yes No

This study was explained to me by _____

I agree to take part in the study by:

1. Being interviewed Yes No
2. Writing and sharing my thoughts, feelings, experiences Yes No N/A
3. Being observed during a normally scheduled shift Yes No N/A
4. Giving the researcher permission to revisit my data in future studies with permission from an ethics board. Yes No

_____ _____ _____

Signature Date Printed Name

I believe the person who has signed this document understands the purpose of this study, their participation within the study and has voluntarily given their consent.

_____ _____

Signature of Investigator or designate Date

Appendix F
Recruitment Notice

What is the Preceptorship Experience Like in a Rural Setting?

Research Study

Seeking 4th year Nursing Students
In Nursing 495
Going to a Rural Hospital

What?
Willing to talk about your preceptored clinical experience
You may be asked to be observed during a regularly scheduled shift

When?
Interviews will be conducted at a mutually convenient time and place for about 1- 2 hours

Sound like fun?
Contact me at the address below for more information

Investigator:
Monique Sedgwick, RN, PhD (s)
Faculty of Nursing
3rd floor Clinical Sciences Building
University of Alberta
Phone: 780-539-2986
780-814-4915

Co-investigator:
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Assistant Professor
Faculty of Nursing
University of Alberta
Phone: 780-492-9821

Co-investigator:
Dr. O. Yonge, RN, PhD
Professor and Vice-Provost (Academic Programs)
University of Alberta
Phone: 780-492-2280

Appendix G
Interview Guide

Descriptive Question

Grand-tour, general question:

"Could you describe what the rural hospital experience is like for you?"

For student and RN participants:

Structural Questions

1. What does preceptorship mean to you? What are the roles, responsibilities of the preceptor and of you, as student?

2. What values and beliefs do you have about preceptorship?

3. Why did you choose a rural experience? What do you hope to get out of it? What advantages/limitations does it have over other senior practicum opportunities?

4. Do ties to the community and its' members impact the type of nursing care provided here in this hospital? How/ Why?

5. What is working during this experience, and why? What is not working and why?

6. What would you tell other students who are considering a rural senior practicum?

Contrast Questions

7. How different is this experience to your other practicums? Why? Probe for differences in level of student versus having instructor/preceptor or urban/rural difference.

8. Tell me about typical rural hospital experiences and atypical experiences.

9. How does rural nursing differ from nursing in urban areas? How does this then alter the preceptorship process and experience?

10. What has it been like becoming part of the rural hospital team? How is this different to your other experiences?

11. What has helped you feel like you are/not part of the team?

12. What would you tell the U of A nursing faculty about the rural senior practicum experience?

For Preceptors:

Structural Questions

1. What does preceptorship mean to you? What are the values, norms, experiences, roles associated with preceptorship?
2. How does the rural environment influence those things?
3. Do ties to the community and its' members impact the type of nursing care provided here in this hospital? How/ Why?
4. How do you prepare to be a preceptor in general, for this student?
5. How would you prepare a student for a rural preceptorship experience?
6. Describe a good student candidate for a rural preceptored experiences. Describe a student who would not be a good candidate. Why?
7. What is it like bringing a nursing student into the rural hospital team? What facilitates/hinders this occurring?
8. What is working during this experience, and why? What is not working and why?

Contrast Questions

9. Tell me about typical rural hospital experiences and atypical experiences.
10. How does rural nursing differ from nursing in urban areas? How does this then alter the preceptorship process and experience?
11. What makes a student successful in this context?
12. What would you tell other students who are considering a rural senior practicum?
13. What would you tell the nursing faculty about the rural senior practicum expectations and experience?

For Focus Group:

Structural Questions

1. What does preceptorship mean to you? What are the values, norms, experiences, roles associated with preceptorship?

2. What is it like having a student working on the unit?

3. What are the advantages/disadvantages?

Contrast Questions

4. How different is the rural setting to an urban one? Why? How does this influence the student experience?

5. What is it like bringing a nursing student into the rural hospital team? What facilitates/hinders this occurring?